Supreme Court, U.S.
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No.

IN THE

Supreme Court of the United States

STANDARD INSURANCE COMPANY,

Petitioner,

v.

REX T. KEARNEY, JR.,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether an ERISA administrator's determination that a claimant is no longer "disabled" within the meaning of the ERISA plan is subject to review for abuse of discretion where the plan provides that the claimant must provide the administrator with "satisfactory written proof" of disability?

STATEMENT PURSUANT TO RULE 29.6

Petitioner, Standard Insurance Company, is wholly owned by StanCorp Financial Group, Inc. which is publicly traded. No publicly held company owns 10% or more of its stock.

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OPINIONS BELOW

The *en banc* opinion of the United States Court of Appeals for the Ninth Circuit is reported at 175 F.3d 1084 (9th Cir. 1999) and is printed at Appendix A. The order granting rehearing *en banc* and withdrawing the panel decision is reported at 152 F.3d 1098 (9th Cir. 1998) and is printed at Appendix B. The Ninth Circuit panel opinion, twice amended, that was withdrawn by the *en banc* court is reported at 144 F.3d 597 (9th Cir. 1998) and is printed at Appendix C. The unpublished opinion and judgment of the United States District Court for the Eastern District of California is printed at Appendix D.

STATEMENT OF JURISDICTION

The *en banc* decision of the United States Court of Appeals for the Ninth Circuit was filed and entered on April 28, 1999 (App. A). This Court has jurisdiction pursuant to section 1254 of Title 28 of the United States Code.

STATEMENT OF THE CASE

A. The Challenged Benefits Determination

Respondent Rex T. Kearney, Jr., an attorney, received benefits under a long-term disability policy (the "LTD Policy") issued by petitioner Standard Insurance Company ("Standard") for just over three years after undergoing by-pass surgery. The LTD Policy funded a long-term disability plan ("the Plan") covered by the Employee Retirement Income Security Act of 1974 ("ERISA"). The LTD Policy provided in relevant part that:

> STANDARD will pay the LTD benefit described in Part 8 upon receipt of satisfactory written proof that you have become DISABLED while insured under the GROUP POLICY.

App. C at 54a.

The LTD Policy contained several other provisions dealing with Standard's authority and discretion in handling claims under the LTD Policy. The portion of the LTD Policy dealing with "Claims Provisions and Procedures" required the claimant to provide "written authorization for STANDARD to obtain the records and information needed to determine [the claimant's] eligibility for LTD BENEFITS." CR 47 at 332.[1]

The LTD Policy also required the claimant to provide Standard with satisfactory proof of loss:

> Proof of each of the following elements of proof of loss must be provided to STANDARD at your expense. No LTD BENEFITS will be paid until STANDARD receives *satisfactory* written proof:
>
> 1. That you became DISABLED while insured under the GROUP POLICY.
>
> 2. That you were DISABLED throughout the ELIMINATION PERIOD and the period for which LTD BENEFITS are claimed.

---

1. The "CR" cites are to the relevant tab and page number in the Excerpts of Record filed by the parties in the Ninth Circuit.

3. That your DISABILITY results from a cause not excluded in Part 7.

4. That you are being seen regularly and treated by a PHYSICIAN.

5. Of such additional information as STANDARD may reasonably require in connection with your claim for LTD BENEFITS.

If your claim is approved, no LTD BENEFITS will be continued beyond the end of the period for which you have provided STANDARD with *satisfactory written proof of loss*.

CR 47 at 331 (emphasis supplied).

Consistent with its discretion to decide claims, the LTD Policy also gave Standard the absolute right to investigate:

> STANDARD has the right at any time to conduct an investigation of your claim. No LTD BENEFITS will be paid until STANDARD has had a reasonable time to conduct an investigation.

CR 47 at 333.

Likewise, Standard could require the claimant to submit to an independent examination:

> STANDARD has the right to have you examined at STANDARD'S expense at

> reasonable intervals while you are claiming LTD BENEFITS. Any such examinations will be conducted by one or more PHYSICIANS or vocational specialists of STANDARD'S choice.

CR 47 at 333. In accord with this provision, after Kearney had been receiving benefits for almost a year and a half, Standard asked Kearney to submit to an examination by an independent medical examiner specializing in neuropsychology. App. C at 58a. After examining Kearney and reviewing the materials in his claim file, Dr. Randall Smith reported that his

> evaluation of Mr. Kearney does not reveal any evidence of cognitive, verbal skill, or memory deficits which would preclude him from effectively functioning as an attorney at the present time. . . . I can certainly find no evidence of neuropsychological deficits which would prompt him to be labeled disabled. Those physicians who have drawn such conclusions have done so simply based on the patient's self-report, and not as a result of formal or systematic evaluation.

App. C at 59a.

Based on the information in Kearney's file — including a report that Kearney had resumed working on race cars and had participated in races at speeds in excess of 100 miles per hour — Standard advised Kearney in a letter dated September 6, 1994 that Standard had decided to close his claim because he was no longer "disabled" as that term is defined in the LTD Policy. App. C at 60a. Standard informed

Kearney that he could request that Standard review its benefits determination and explained the sort of information that would be relevant to such review.

In response to this notice, Kearney requested and Standard conducted an independent review of the decision to close his claim, including review of additional medical information that Kearney submitted in support of his claim. App. C at 60a-62a. At the conclusion of that review, Standard explained that it had examined all of the information in Kearney's claim file to determine "if there is sufficient medical evidence to support [his] claim of disability from his occupation as a trial attorney" and had concluded that there was not. App. C at 62a.

The record evidence of Kearney's physical and mental condition that Standard reviewed included the following: Kearney was diagnosed by one of his own cardiologists as having a "Class 1" functional cardiac status (CR 47 at 637) which describes "[p]atients with cardiac disease but with no limitation of physical activity. Ordinary activity causes no undue dyspnea, anginal pain, fatigue or palpitation." CR 47 at 357. Kearney restored vintage race cars and — approximately 10 times a year — participated in races of those cars in which the participants would drive the cars as fast as 110-120 miles per hour. CR 47 at 582. He played doubles tennis each weekend for two periods "up to 2-3 hours" at a time. CR 47 at 582. He reported that he was unable to play as many sets of tennis as he used to play. CR 47 at 624.

As for his mental condition, a mental status examination by one of Kearney's doctors revealed: appropriate affect to thought content; no evidence of communication disorder;

logical and goal-directed stream of thought; intact associations; excellent interpretation of proverbs indicating no problems with abstract thinking; no evidence of delusional thinking; proper orientation as to time, date, place and person; no evidence of auditory or visual hallucinatory experiences; estimated intelligence overall is superior; ability to remember a number, color and flower after ten minutes, three of three objects after 15 minutes, and repeat 7 digits forward and 6 in reverse; remote memory intact; good with dates and past events; superficially, no deficit in learning but possible subtle cognitive deficiencies; satisfactory problem solving. CR 47 at 653.

Tests by Dr. Smith produced substantially similar results: He concluded that Kearney could function at a level of superior intelligence; there was no evidence of cognitive deficiencies in formal testing; he performed exceptionally well on the mental status examination; there was no evidence of memory dysfunction which would preclude him from functioning effectively as an attorney; the primary impediment to Kearney returning to full-time employment as an attorney was motivational; Kearney believed that, unless he was willing and/or able to work 75 hours per week in an almost hypomanic state, he could not function at all as a trial attorney; testing did not reveal any evidence of cognitive, verbal skill, or memory deficits which would preclude him from functioning as a trial attorney. CR 47 at 591-92.

Standard discussed the foregoing record evidence and explained why it failed to demonstrate that "he is so impaired mentally and physically that he is unable to practice as a trial attorney." App. C at 62a-63a.

B. Proceedings Below

1. *The District Court Decision*

The district court agreed with Standard's assessment of the record and the LTD Policy and granted Standard's motion for summary judgment on plaintiff's claim that Standard improperly terminated his benefits. Applying *de novo* review to Standard's benefits determination, the district court ruled in relevant part: (1) The relevant inquiry in assessing whether plaintiff is "disabled" within the meaning of the LTD Policy is whether "he is unable to perform the material duties of a trial attorney" (App. D at 93a); (2) "Plaintiff retains the burden of making this showing" (App. D at 93a); (3) The record evidence does not "indicate that his mental limitations and related physical restrictions prevent him from resuming the duties of a trial attorney" (App. D at 93a, 97a); (4) "The fact that plaintiff should, like most of us, avoid severe emotional stress or very hard work does not warrant the conclusion that he cannot practice as a trial attorney" (App. D at 96a); and (5) "[T]here is no question that plaintiff's physical and mental stamina has been weakened by his heart condition. Unfortunately, the LTD Policy does not insure that he would forever remain at his former state of health and stamina. Without sufficient evidence that the condition left him so disabled that he cannot perform the functions of a trial attorney, plaintiff's claim fails." App. D at 97a.

2. *The Ninth Circuit Panel Decision*

Shortly after the district court granted summary judgment in favor of Standard, applying *de novo* review to Standard's benefits decision, the Ninth Circuit held in *Snow v. Standard Insurance Company*, 87 F.3d 327 (9th Cir. 1996),

that Standard's benefits determinations could be reviewed only for *abuse of discretion* under a plan containing identical language regarding Standard's discretion to determine eligibility for benefits. 87 F.3d at 330. Notwithstanding the squarely contrary intervening ruling in *Snow*, however, the *Kearney* panel held that *de novo* review applied to Standard's benefits decision in this case. App. C at 66a-68a. The panel also held that because *de novo* review applied, Standard did not "retain discretion to give meaning to its own standard" for disability, and, instead, "may deny benefits only to the extent that courts independently would conclude that the evidence fails to constitute satisfactory written proof" of disability. App. C at 68a. Even though the district court affirmed Standard's decision under *de novo* review, the panel concluded that the case had to be remanded to allow "Kearney to present: (1) medical evidence aimed at explaining and resolving the somewhat conflicting medical diagnoses; and (2) evidence describing the material duties of trial attorneys." App. C at 79a-80a.

3. *The Ninth Circuit* En Banc *Decision*

Based on the clear conflict between the panel decision in *Kearney* and the earlier decision in *Snow*, the Ninth Circuit voted *en banc* to withdraw the panel decision in *Kearney* and rehear the appeal to resolve the intra-Circuit conflict. In a split decision, the *en banc* court ruled that Standard's reservation of discretion to determine eligibility for benefits under the policy insuring the ERISA plan at issue was not sufficiently unambiguous to trigger "abuse of discretion" review of Standard's eligibility decisions.

The majority held that the issue turned on the meaning of the plan language requiring the claimant to provide

Standard with "satisfactory written proof" of disability. The court ruled that those words, taken on their own, were susceptible to three alternative constructions: (i) they can be given a "reading natural to a lawyer experienced in insurance litigation," which would give Standard "discretion . . . to decide whether the quantum of proof is sufficient, as opposed to whether the loss is covered"; (ii) the words can be read to establish an objective standard of proof, *i.e.*, what a "reasonable person" would consider satisfactory as opposed to what Standard would consider satisfactory; or (iii) the words can be read, as Standard and the dissent read them, to give Standard discretion to determine, subject to its fiduciary duty, whether the written proof is satisfactory. App. A at 10a-12a. Based on these alternative constructions, the majority held in relevant part that the Plan did not "unambiguously" grant Standard discretion to determine eligibility for benefits, and that Standard's decisions were therefore subject to *de novo* review. App. A at 13a. The court remanded for the district court to address certain "issues of fact" connected with the disability claim. App. A at 21a.

REASONS FOR GRANTING THE WRIT

I.

THE PETITION SHOULD BE GRANTED BECAUSE THE COURTS OF APPEALS ARE CLEARLY DIVIDED ON WHAT ERISA PLAN LANGUAGE IS NECESSARY TO VEST A PLAN ADMINISTRATOR WITH DISCRETION TO DETERMINE ELIGIBILITY FOR BENEFITS UNDER THE PLAN.

This petition offers a textbook case for this Court's intervention. The Courts of Appeals are clearly divided on the important ERISA standard of review issue presented, and there is no reason to suppose that the split will resolve itself.

In this case, the Ninth Circuit, sitting *en banc*, reviewed the ERISA plan language set out above and held in relevant part:

> We cannot conclude that Standard "unambiguously retained" discretion by means of the phrase "satisfactory written proof that you have become disabled," because the phrase is subject to at least two reasonable constructions to the contrary. Thus we conclude that the district court was correct in its determination that Mr. Kearney's claim should be reviewed de novo.

App. A at 13a.

The Second Circuit agrees. In *Kinstler v. First Reliance Standard Life Ins. Co.*, the Second Circuit held that

> it is not clear whether the key language, requiring the claimant to "submit[ ] satisfactory proof of Total Disability to us," means only that the claimant must submit to First Reliance proof that is satisfactory or that the claimant must submit proof that is satisfactory to First Reliance. Since the plan administrator bears the burden of proving that the arbitrary and capricious standard of review applies . . . we think the needless ambiguity in the wording of the policy should be resolved against First Reliance.

1999 WL 388022, *8 (2nd Cir. Jun. 15, 1999) (citing *Kearney*).

The Sixth Circuit, however, recently ruled *en banc* that materially indistinguishable plan language requires a court to review an ERISA administrator's decision for abuse of discretion:

> We agree with Aetna that this "right to require as part of the proof of claim satisfactory evidence" means, semantically, that the evidence must be satisfactory to Aetna, the only named party with the right to request such evidence. It naturally follows that Aetna, the receiver of the evidence, would review that evidence to determine if it constitutes satisfactory proof of total disability. . . .
>
> In short, reading the contractual language in an ordinary and popular sense as we must, the only reasonable interpretation of the Plan is that Aetna requests the evidence, reviews it, and then

> makes a benefits determination. . . . We therefore conclude that the plan clearly grants discretion to Aetna because, under the only reasonable interpretation of the language, Aetna retains the authority to determine whether the submitted proof of disability is satisfactory.

Perez v. Aetna Insurance Co., 150 F.3d 550, 556-557 (6th Cir. 1999) (*en banc*).

The Seventh Circuit agrees. *See Patterson v. Caterpillar, Inc.*, 70 F.3d 503, 505 (7th Cir. 1995) ("The Caterpillar Plan provides that 'benefits will be payable only upon receipt by the Insurance Carrier or Company of such notice and such due proof, as shall from time to time be required, of such disability.' This language is similar to provisions that we previously have held sufficient to apply the arbitrary and capricious standard of review.").

The Courts of Appeals have candidly acknowledged the split in authority that this petition is asking the Court to resolve. The majority in *Kearney* recognized that its decision was squarely contrary to the Sixth Circuit's *en banc* construction of nearly identical plan language, with which the dissenting judges in *Kearney* agreed: "The dissent's position is in accord with [the Sixth Circuit's decision in] *Perez*, 150 F.3d 550, although the phrasing of the clause there was slightly different. We concede the reasonableness of the dissent's reading. But . . . [w]e reject the proposition that the dissent's is the only reasonable reading." App. A at 12a.

The Second Circuit very recently highlighted the disagreement and confusion among the Courts of Appeals on this issue:

> [A]ppellate judges are divided on the issue of what language suffices to convey to plan administrators the discretionary authority that warrants the more deferential arbitrary and capricious standard of review. This dispute is well illustrated by the Sixth Circuit's decision in *Perez v. Aetna Life Insurance Co.*, 150 F.3d 550 (6th Cir. 1998) (in banc), in which eight judges of the Court deemed the phrase "satisfactory evidence" sufficient to preclude de novo review, *see id.* at 555-58, and six judges found this phrase insufficient, *see id.* at 558-61 (Boggs, J., dissenting). The Ninth Circuit, also sitting in banc, has deemed insufficient the phrase "satisfactory written proof," *Kearney*, __ F.3d __, 1999 WL 246485, at *3-*5. The Seventh Circuit has deemed sufficient the phrase "proof . . . satisfactory to us, [i.e., the administrator]" *Donato*, 19 F.3d at 379 (emphasis added), but has also deemed sufficient the less rigorous phrase "such due proof, as shall be from time to time required." *Patterson v. Caterpillar, Inc.*, 70 F.3d 503, 505 (7th Cir. 1995).

Kinstler, 1999 WL 388022 at *7.

There is no benefit to allowing this issue to "percolate" any longer in the lower courts: the split in authority is established and unlikely to resolve itself absent intervention by this Court. This is particularly true because the current split in authority includes two diametrically opposed decisions by *en banc* courts — each of which was a split decision in which the opposing view was thoroughly argued by the dissenting judges. The Courts of Appeals simply disagree about this critical issue.

In addition to satisfying this traditional criterion for certiorari review, this case offers the Court a particularly good vehicle for resolving the ERISA issue presented in the petition: the issue was clearly raised and adjudicated at the district court and appellate levels, both sides of the issue will be ably briefed, and there are no procedural impediments to reaching and deciding the issue presented. In short, this split in authority is one which the Court needs to resolve, and it should do so by taking this case.

II.

THE PETITION SHOULD BE GRANTED BECAUSE THE ISSUE PRESENTED IS OF WIDESPREAD SIGNIFICANCE, AND UNIFORMITY AMONG THE CIRCUITS IS CRITICAL TO THE PROPER FUNCTIONING OF ERISA.

The standard of review applied to an ERISA administrator's benefits decision goes to the core of the relationship between benefit providers and recipients that is governed by ERISA. The significance of this issue — and the need for this Court to weigh in at this juncture — is demonstrated by the sheer volume of appellate decisions that have wrestled with defining the plan language required to give an administrator discretion to determine eligibility for benefits under an ERISA plan. In addition to the conflicting Ninth Circuit and Sixth Circuit *en banc* decisions discussed above, every Circuit has confronted this question since this Court held in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989), that a plan *could* give an ERISA

administrator discretion to determine eligibility for plan benefits or construe plan terms.[2]

The unavoidable result of the Circuits' irreconcilable positions on this issue is the precise lack of uniformity that ERISA was enacted to eliminate. *See Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 10 (1987). As things now stand, a decision by an administrator under the plan at issue in this case that is challenged in California or New York is subject to a different standard of review than a decision by the same administrator under the same plan on the same facts that is challenged in Michigan or Illinois. This Court has long recognized that subjecting benefit providers to disparate legal regimes increases the risk that employers will opt not to offer certain benefits to their employees. *See id.* By granting the petition and resolving the Circuit split, this Court will ensure the uniformity of law essential to effective cost containment and the correlative increase in the availability of benefits to plan beneficiaries.

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2. *See, e.g., Curtis v. Noel*, 877 F.2d 159, 161 (1st Cir. 1989) (and cases following); *Kinstler*, 1999 WL 388022 (2d Cir. 1999) (discussing 2d Cir. cases); *Luby v. Teamsters Health, Welfare, & Pension Trust Funds*, 944 F.2d 1176, 1180 (3d Cir. 1991) (and cases following); *De Nobel v. Vitro Corp.*, 885 F.2d 1180 (4th Cir. 1989) (and cases following); *Lowry v. Bankers Life & Casualty*, 871 F.2d 522, 524 (5th Cir. 1989) (and cases following); *Patterson*, 70 F.3d at 505 (discussing 7th Cir. cases); *Baxter v. Lynn*, 886 F.2d 182, 187-88 (8th Cir. 1989) (and cases following); *Pratt v. Petroleum Product Management Employee Savings Plan*, 920 F.2d 651, 657-58 (10th Cir. 1990) (and cases following); *Guy v. S.E. Iron Workers' Welfare Fund*, 877 F.2d 37, 39 (11th Cir. 1989) (and cases following); *Block v. Pitney Bowes Inc.*, 952 F.2d 1450, 1452-54 (D.C. Cir. 1992) (and cases following).

CONCLUSION

For the foregoing reasons, the petition for writ of certiorari should be granted.

Respectfully submitted,

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APPENDIX

APPENDIX A — OPINION OF THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT DATED AND FILED APRIL 28, 1999

Rex T. KEARNEY, Jr.,
Plaintiff-Appellant,
v.
STANDARD INSURANCE COMPANY,
Defendant-Appellee.

Nos. 96-16539, 96-16701.

United States Court of Appeals,
Ninth Circuit.

Filed April 12, 1998.

Amended May 19, 1998.
Amended June 3, 1998.
Rehearing En Banc Granted and
Opinion Withdrawn Aug. 3, 1998.
Argued and Submitted Sept. 24, 1998.
Filed April 28, 1999.

* * *

KLEINFELD, Circuit Judge:

This is an ERISA case. We voted to rehear it en banc to reconcile our decisions on the district court standard of review, whether de novo or abuse of discretion, of a plan administrator's decision. We also consider what record that the district court should consider.

Appendix A

Facts.

Mr. Kearney was a trial lawyer, and the managing partner of his law firm. As part of its benefits package, the firm bought a group disability insurance policy from Standard Insurance Company. The law firm was the policy owner. Under the policy, Standard promised to pay a percentage of an employee's predisability earnings, if the employee became disabled. For attorneys, the policy definition of "disability" says "[y]ou are only required to be DISABLED from your specialty in the practice of law."

One day Mr. Kearney was in a judge's chambers with opposing counsel, when the judge told him he "looked like hell." When opposing counsel gave him exhibits to look at, he had trouble focusing and felt faint. Mr. Kearney was then 54 years old, with a history of heart trouble, so he went immediately to his physician. He had had a heart attack eleven years earlier, and an angioplasty four years earlier. This time, he was diagnosed with unstable angina pectoris, which basically means chest pain caused by inadequate oxygen supply to the heart. The arteries serving his heart were diseased and partially blocked. He was admitted to the hospital and coronary bypass surgery was performed, grafting in new blood vessels.

The parties disagree about how well Mr. Kearney recovered after surgery. The insurer takes the position that Mr. Kearney has recovered fully enough to practice in his specialty again, but Mr. Kearney's position is that he has not. Mr. Kearney returned to his law practice for a while, then retired. Mr. Kearney takes the position that since his

surgery, fatigue, exhaustion, and memory and concentration problems, prevent him from practicing as a trial lawyer.

Mr. Kearney applied for disability benefits. Standard paid them for two years. Then after obtaining more medical information from Mr. Kearney and from physicians it consulted, the insurer took the position that Mr. Kearney was no longer disabled, and quit paying him.

Mr. Kearney asked Standard to review its denial. It did so and reached the same conclusion. A "Quality Assurance Specialist" in the insurer's "Group Quality Assurance Unit," which reviewed the denial, wrote him that the "Quality Assurance Unit" performed "an independent review conducted separately from the individuals who made the original claim determination." The thorough letter reviews the medical evidence in three-and-a-half single-spaced pages. It concludes that Mr. Kearney's heart and brain both test out satisfactorily on objective measures, and his lifestyle (playing several sets of tennis every weekend and racing cars at speeds of up to 120 miles per hour) is inconsistent with his claimed inability to perform the functions of a trial lawyer.

Mr. Kearney sued Standard under 29 U.S.C. § 1132(a)(1)(B) for benefits. The statute cited is the provision of ERISA providing for civil actions to recover benefits under an ERISA plan. The parties filed cross motions for summary judgment. The insurer argued that it was entitled to deferential review for abuse of discretion, and that review should be confined to what it called the "administrative record," that is, the papers the insurer had

when it denied the claim. The court determined that review should be de novo, because the policy was ambiguous about whether discretion was conferred. The court further determined that review should be confined to what the insurer had before it, because Mr. Kearney had had sufficient opportunity to provide evidence to the insurer. On the substantive question of whether Mr. Kearney was disabled, the dispute boiled down to whether his memory and intelligence, and his ability to work very hard and bear stress, had so deteriorated, that he could not function effectively as a trial lawyer. The district court concluded that Mr. Kearney's IQ of 130, his playing several sets of tennis every weekend, his car-racing up to 120 miles per hour about ten times a year, and medical opinion that he ought to be able to return to work, left no genuine issue of material fact about whether he was disabled. Though his physical and mental stamina were reduced, the court granted summary judgment to the insurer because they were not so reduced as to disable him from practicing law.

Mr. Kearney appealed. The insurer argued that under Snow v. Standard Ins. Co., 87 F.3d 327 (9th Cir.1996), the policy vested discretion in itself as the administrator, so district court review was limited to abuse of discretion. The panel decision, rejecting that argument, said, "[w]e have never held that so imprecise and ambiguous a provision as contained in Kearney's policy vests discretion in the administrator, and we decline to do so now." Kearney v. Standard Ins. Co., 144 F.3d 597, 605 (9th Cir.), withdrawn, 152 F.3d 1098 (9th Cir.1998). But Standard's brief had pointed out that the policy "contains exactly the same language" as the policy in Snow. The petition for rehearing

pointed out that the disability policy construed in Snow, in which we had reached the opposite result, involved a policy from the same insurance company containing identical language. We rehear this case en banc in order to eliminate the conflict between these two decisions that construed identical policy language.

Analysis.

The parties, and the panel opinion, have assumed that the insurer was an "administrator" for purposes of ERISA. Because the question whether the insurer is an administrator has not been disputed in district court or in the briefs, we assume for purposes of discussion that it is, although the characterization is not without doubt.[1]

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1. The statute provides that the administrator is the person so designated in the instrument. 29 U.S.C. § 1002(16)(A)(i)-(ii). The instrument (in this case the insurance policy) says in Part 6 that the policy "and the application" constitute the contract. The application designates the law firm, not Standard Insurance Company, as "plan administrator." This is consistent with the common arrangement, whereby the employer, union, or some employer-union trust, is the administrator of an ERISA plan. The statutory default, in the absence of designation of an administrator, is that the "plan sponsor," which is the employer in a case like this, is the administrator. 29 U.S.C. § 1002(16)(A)(ii), 29 U.S.C. § 1002(16)(B)(i). The ERISA plan, according to the "ERISA information and ERISA notice of your rights" published by

(Cont'd)

Appendix A

I. Standard of review.

The insurer argues that, as administrator, it is entitled to deferential review, limited to whether it abused its discretion based on the materials it had before it. The district court concluded that its review should be de novo, without deference to Standard's decision.

The policy says that Standard will pay disability benefits "upon receipt of satisfactory written proof that you

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(Cont'd)

Standard for employees of the firm said that they had the right to "have the PLAN ADMINISTRATOR review and consider any denial of your claim." The designated administrator, Mr. Kearney's law firm, had ceased its practice and had no employees by the time Standard issued its final denial.

A Standard house counsel's affidavit in the record says that the ERISA notice of rights quoted above contained a scrivener's error, and "should have read" "Standard" where it said "the plan administrator." Mr. Kearney disputes whether Standard is entitled to the benefit of what it meant to say as opposed to what it did say, and argues in his reply brief (but not his opening brief) that the law firm was the administrator, but does not argue that this bears on the standard of review issue.

We need not decide, because the briefs do not put the issue before us, how the case might proceed were the insurer not deemed to be the administrator. Compare Moran v. Aetna Life Ins. Co., 872 F.2d 296 (9th Cir.1989) with Vega v. National Life Ins. Services, Inc., 145 F.3d 673, 677 n. 24 (5th Cir.1998). We proceed on the same basis that the parties did, that Standard was the administrator.

have become DISABLED." Standard argues that the word "satisfactory" implies discretion in Standard to decide whether the claimant really is disabled within the policy definition based on the proof submitted. Therefore, Standard argues, if the insurer reasonably exercised discretion to deny a claim, a court cannot substitute its own judgment, or consider other proof, and grant the claim.

The statute does not say how courts are supposed to review administrators' claim denials. We therefore begin our analysis with Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989), which does. In Firestone, a question arose whether employees of plants sold by Firestone to Occidental Petroleum, who were rehired by Occidental, were entitled to severance pay under Firestone's ERISA plan. Firestone interpreted the plan to mean that they were not.

The Supreme Court granted certiorari in part to "address the appropriate standard of judicial review of benefit determinations by fiduciaries or plan administrators under ERISA." Id. at 105, 109 S.Ct. 948. Firestone argued that because ERISA defined a fiduciary as one who "exercises any discretionary authority," 29 U.S.C. § 1002(21)(A)(i), it could be inferred that, as a fiduciary, they had discretion and their decisions could be reviewed only for arbitrariness and capriciousness. A number of circuits had adopted the arbitrary and capricious standard. But the Supreme Court rejected it. It held that because there was "no evidence that under Firestone's termination pay plan the administrator has the power to construe uncertain terms or that eligibility determinations are to be given deference," judicial review

had to proceed without any deference to Firestone's determination. Firestone, 489 U.S. at 111, 109 S.Ct. 948.

Noting that "ERISA abounds with the language and terminology of trust law," the Court used the Restatement (Second) of Trusts and other trust law authorities to apply "[t]rust principles." Firestone, 489 U.S. at 110-11, 109 S.Ct. 948. Firestone establishes that "[a]s they do with contractual provisions, courts construe terms in trust agreements without deferring to either party's interpretation." Id. at 112, 109 S.Ct. 948. That means that except where the plan gives the trustee discretion to interpret the terms of its trust, courts review trust provisions de novo, which is to say they decide for themselves what a term of the trust means instead of deciding whether the plan administrator was reasonable in how it construed the term. " 'The extent of the duties and powers of a trustee is determined by the rules of law that are applicable to the situation, and not the rules that the trustee or his attorney believes to be applicable, and by the terms of the trust as the court may interpret them, and not as they may be interpreted by the trustee himself or by his attorney.' " Firestone, 489 U.S. at 112, 109 S.Ct. 948 (quoting 3 W. Fratcher, Scott on Trusts § 201, at 221) (emphasis added by Firestone).

Firestone holds that a deferential standard of review for actions by the trustee is "appropriate when the trustee exercises discretionary powers." Id. at 111, 109 S.Ct. 948. Though the Court cites Restatement (Second) of Trusts § 187 for this proposition, the Court puts a slightly different gloss on the proposition than does the Restatement. The Restatement says that "exercise of a power is discretionary

except to the extent to which its exercise is required by the terms of the trust or by the principles of law applicable to the duties of trustees." Restatement (Second) of Trusts § 187 comment a (1959). Thus under the Restatement, in default of anything to the contrary, the trustee has discretion in the exercise of the powers the trust confers. But the Court holds in Firestone that "denial of benefits challenged under [29 U.S.C.] § 1132(a)(1)(B) is to be reviewed under a de novo standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." Firestone, 489 U.S. at 115, 109 S.Ct. 948. That means the default is that the administrator has no discretion, and the administrator has to show that the plan gives it discretionary authority in order to get any judicial deference to its decision.

Thus our task now is to examine the instrument to determine whether it confers discretion on Standard to decide whether a claimant is disabled. The language Standard relies on for its argument that the instrument confers discretion is the word "satisfactory" in the requirement in the insuring clause that a claimant provide "satisfactory written proof" of disability:

> Part 6. LONG TERM DISABILITY INSURING CLAUSE
>
> Subject to all the terms of the GROUP POLICY, STANDARD will pay the LTD BENEFIT described in Part 8 upon receipt of satisfactory written proof that you have become DISABLED while insured under the GROUP POLICY.

Appendix A

A majority of us have concluded that the phrase "will pay the LTD BENEFIT described in Part 8 upon receipt of satisfactory written proof that you have become DISABLED" is ambiguous. At least three interpretations are reasonable.

One reading natural to a lawyer experienced in insurance litigation would be that "satisfactory written proof" is a variant of the very old phrase "satisfactory proof of loss." Such phrases have been used in insurance policies for at least a century. The phrase traditionally confers discretion on the insurance company to decide whether the quantum of proof is sufficient, as opposed to whether the loss is covered. The word "satisfactory" is traditionally limited by an objective standard, so that the insurance company is not permitted to reject proof that would be satisfactory to a reasonable person. See Charles R. Elliott, A Treatise on the Law of Insurance 319 (1907); William R. Vance, Handbook on the Law of Insurance 897 (Buist M. Anderson ed., 3d ed.1951) (1904); 13A Couch on Insurance § 49A:27 (2d ed. rev.1982); 3 Insurance Law and Practice § 1443 (John Alan Appleman & Jean Appleman, rev. ed.1967).

A second reading of "will pay . . . upon receipt of satisfactory written proof that you have become DISABLED" applies "satisfactory" to whether the proof establishes a covered disability as well as whether there is enough of it, but construes the word "satisfactory" as objective rather than subjective. Thus "satisfactory written proof that you have become disabled" means "proof that would be satisfactory to a reasonable person that you have

become disabled." Though the Sixth Circuit rejected this reading, Judge Boggs in dissent urged it persuasively. See Perez v. Aetna Life Ins. Co., 150 F.3d 550, 559 (6th Cir.1998) (en banc) (Boggs, J., dissenting). This reading is consistent with well established common law principles for reading contracts, which are the principles that we are required, under Firestone, to apply. As a matter of common law, where a contract contains a condition that the obligor be "satisfied," "an interpretation is preferred under which the condition occurs if . . . a reasonable person in the position of the obligor would be satisfied." Restatement (Second) of Contracts § 228 (1981). There is an exception to this objective construction, where the subject matter can only be subjectively and not objectively satisfactory (e.g., "if you paint a portrait of my daughter with which I am entirely satisfied, I'll pay you $5,000 for it"), id. at illustration 4, but satisfactory proof of disability is not inherently subjective, so the exception does not apply. This objective reading subjects the obligor to a more stringent test than that his dissatisfaction must be genuine and in accord with the duty of good faith and fair dealing. Even honest dissatisfaction will not avoid his obligation, if a reasonable person in his position would be satisfied. Id. at comments a & b.

A third reasonable construction is the one articulated in the dissent, that "will pay . . . upon receipt of satisfactory written proof that you have become DISABLED" means that, subject to its fiduciary duty,[2] if the administrator is

2. Kearney also urges us to apply less deferential review because of Standard's potential conflict of interest (it is deciding (Cont'd)

not satisfied (and has not abused its discretion in so deciding), then it does not have to pay. The dissent's position is in accord with Perez, 150 F.3d 550, although the phrasing of the clause there was slightly different. We concede the syntactical reasonableness of the dissent's reading. But the dissent goes too far, by suggesting that if anything is committed to the administrator's discretion, then everything is. And the dissent's reading runs contrary to the common law construction of conditions of "satisfaction." We reject the proposition that the dissent's is the only reasonable reading.

Only by excluding alternative readings as unreasonable could we conclude that the conferral of discretion is unambiguous. There are at least three fair readings of the phrase with quite different consequences. Thus we are compelled to conclude that, to the extent discretion is conferred, the conferral and its scope are at best ambiguous, and at worst (from Standard's viewpoint) the phrase does not confer discretion at all because it does not say that it does.

(Cont'd)

whether it owes its own money to Kearney). See Atwood v. Newmont Gold Co., 45 F.3d 1317 (9th Cir.1995); Lang v. Long-Term Disability Plan, 125 F.3d 794 (9th Cir.1997). Because we conclude that Kearney is entitled to de novo review, which gives no deference at all to Standard's decision, we do not reach the question whether he would be entitled to less deferential review were he entitled only to review for abuse of discretion. Thus we have no occasion to reconsider the validity of Atwood and Lang in light of Firestone Tire & Rubber v. Bruch, 489 U.S. 101, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989).

Appendix A

In Bogue v. Ampex Corp., 976 F.2d 1319, 1325 (9th Cir.1992), we held that an administrator had discretion only where discretion was "unambiguously retained" by the administrator. This is consistent with the established principles that ambiguities are construed contra proferentem, and that ambiguities are construed in favor of the insured. Mongeluzo v. Baxter Travenol Disability Benefit Plan, 46 F.3d 938, 942 (9th Cir.1995). We cannot conclude that Standard "unambiguously retained" discretion by means of the phrase "satisfactory written proof that you have become disabled," because the phrase is subject to at least two reasonable constructions to the contrary. Thus we conclude that the district court was correct in its determination that Mr. Kearney's claim should be reviewed de novo.

II. The Record to be Reviewed.

If a court reviews the administrator's decision, whether de novo as here, or for abuse of discretion, the record that was before the administrator furnishes the primary basis for review. Should the district judge review anything else? Standard moved for an order that the district court review only the materials Kearney had submitted to Standard. The district judge granted the order, following our decision in Mongeluzo, 46 F.3d at 943.

In Mongeluzo, we held, following the Fourth Circuit in Quesinberry v. Life Insurance Company, 987 F.2d 1017, 1025 (4th Cir.1993) (en banc), that the district court had discretion to allow evidence that was not before the plan administrator "only when circumstances clearly establish

that additional evidence is necessary to conduct an adequate de novo review." Mongeluzo, 46 F.3d at 944 (quoting Quesinberry, 987 F.2d at 1025) (internal quotation marks omitted). Though we allowed consideration of additional evidence because of circumstances peculiar to that case, we emphasized that "a district court should not take additional evidence merely because someone at a later time comes up with new evidence" and "[i]n most cases" only the evidence that was before the plan administrator should be considered. Id.

On appeal, Mr. Kearney argues that the district court ought to have taken additional evidence regarding the medical relationship between his cardiac condition and his cognitive ability. But the brief does not say what new evidence, nor was any specific new evidence proposed to the district court. The argument is merely a suggestion that the door be opened to whatever new evidence might be developed. But Kearney does not argue that we should reexamine Mongeluzo. Starting the evidence over from scratch would be contrary to Mongeluzo.

In his opposition to Standard's motion to limit the record, Mr. Kearney submitted pages of an "Occupational Outlook Handbook" published by the U.S. Department of Labor, which said that trial lawyers "need an exceptional ability to think quickly" and regularly work "under particularly heavy pressure" when a case is being tried. The district judge exercised his discretion to limit review to the evidence that was before the administrator for two reasons, that Mr. Kearney could as easily have submitted this material to Standard, and that the court did not need it to conduct an adequate de novo review.

The district judge did not abuse his discretion in so ruling. Both reasons he gave for confining the record to what was before Standard are good ones under Mongeluzo and are sensible in the circumstances of this case. No reason has been suggested why Mr. Kearney could not have submitted the pages of the Occupational Outlook Handbook to Standard. Insurance executives would likely be less familiar with what trial lawyers do, and more in need of such a source, than an experienced trial judge. A district judge would likely know, as this judge's remarks indicated he did, what trial lawyers do, without the assistance of a secondary source such as the Occupational Outlook Handbook. The handbook pages are an apt example of "additional evidence . . . not necessary for adequate review of the benefits decision," as well as evidence that could as easily have been submitted to the administrator, which under Mongeluzo are disfavored.

Kearney argues that Standard did not provide the "full and fair review" required by 29 U.S.C. § 1133(2) because it did not obtain the heart films Dr. Weinreb referred to in his report, and did not obtain Dr. Fulton's test data referred to by Dr. Bittle. But Dr. Bittle wrote that he got Dr. Fulton's data from Mr. Kearney's own lawyer, so if Mr. Kearney thought Standard should have reviewed it, he should have sent it to them. As for Dr. Weinreb's films, Kearney argues that Standard's in-house medical advisor suggested that they be obtained, but the context of the suggestion was that he wanted them so he could better criticize Dr. Weinreb's report. Mr. Kearney also argues that Standard failed to comply with the notice provision of 29 C.F.R. § 2560.503-1(f)(3), because it did not tell him what additional material

he needed to submit in order to perfect his claim. The argument is without force, because Kearney's claim did not fail because he failed to submit needed evidence. It failed because Standard, having considered all the evidence, concluded that it needed no more and that Mr. Kearney was not disabled.

III. Genuine Issue of Fact.

Mr. Kearney claimed disability based on fatigue, exhaustion, and mental disabilities following his coronary bypass surgery. He wrote that in tennis, "I am totally wiped out after one set when, before, I played a minimum of six sets on a weekend, sometimes as many as ten or twelve." Stress now caused chest discomfort and exhaustion. "I am unable to focus or concentrate as I did before, and my memory is definitely gone."

Mr. Kearney submitted medical authorizations and other materials so that Standard could develop a claims file enabling it to make a decision. His cardiologist, Stephen L. Morrison, M.D., reported to his internist, David Lehman, M.D., in December 1992, shortly after the surgery, that "I am also concerned about his memory and I am [sic] told him that I am impressed [sic] that this occurs frequently after bypass surgery, and I am hopeful that this will also significantly improve." A few months later, in April 1993, Dr. Morrison wrote that Mr. Kearney "has a tremendous complaint relative to memory loss that he associates with the coronary bypass surgery." The letter says "from a cardiac standpoint he appears to be doing very well," but "he seems very distraught and depressed" and recommended a

tranquilizer. The next month, Mr. Kearney wrote to Dr. Lehman that his memory problem had grown worse.

In February of 1993, Mr. Kearney visited a neurologist, Peter C. Heublein, M.D. Dr. Heublein noted Mr. Kearney's complaints of memory problems and history of heart surgery and of several concussions from auto accidents when Mr. Kearney was a teenager. Dr. Heublein's impression was uncertain, because "my mental status examination now is normal," metabolic disturbance and early Alzheimer's disease were doubtful, and an episode of ischemia or embolus to the brain was possible, as was memory disturbance from anxiety and depression. He recommended a brain scan and psychometric testing to clarify a diagnosis.

An investigator interviewed Mr. Kearney in January 1994 for Standard. Mr. Kearney told him that he was subject to exhaustion and lacking the mental sharpness and memory he once had. He was no longer practicing law actively, and had farmed out his cases. Although his psychiatrist had conducted a battery of tests and told him his memory was normal for a person his age, Mr. Kearney felt it was not up to the standards necessary to conduct trial work. Mr. Kearney was then living on $8,000 a month from Standard, $2,000 a month from other disability insurance with another insurance company, $3,000 a month from his stock portfolio and limited partnerships, interest on $200,000 in savings, state disability income of $300 a week, and a $500,000 fee he had earned as of December 1992.

In the fall of 1994, Mr. Kearney submitted to Standard a lengthy report from Irwin Weinreb, M.D., a cardiologist

hired by a workers' compensation insurer (not Standard) to evaluate Mr. Kearney's workers' compensation claim. Dr. Weinreb's report focuses on whether Mr. Kearney's medical condition was "non-industrial." Mr. Kearney told Dr. Weinreb that he had not seen any doctor since seeing Dr. Lehman and Dr. Morrison, apparently in early 1993, a year and a half before. He told Dr. Weinreb that he had had a brain scan, which had come out normal, as did his MMPI,[3] and his psychiatrist had told him that his memory was normal for his age, but he felt his memory was now inadequate to do trial work. Dr. Weinreb opined that Mr. Kearney's heart condition precluded him from "very heavy work and very severe emotional stress" or a "very tight time schedule," though he "certainly could do legal work outside of trial work." Mr. Kearney's claimed intellectual deficit is mentioned only as history he gave to Dr. Weinreb, not as a finding by Dr. Weinreb.

Standard had Mr. Kearney tested by a psychologist, Randall B. Smith, Ph.D., in May 1994 for evidence of the intellectual and memory deficits he claimed. Mr. Kearney reported that he worked in his office perhaps half an hour per day, raced cars at 110 to 120 mph, played tennis, and exercised. On examination, there was "no evidence of any

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3. The MMPI is the abbreviation for the "Minnesota multiphasic personality disorder inventory," defined as "[a]n empirical scale of an individual's personality based mainly on his own yes-or-no responses to a questionnaire of 550 items; designed to provide scores on all the more important personality traits and adaptations, and including special validating scales which measure the individual's test-taking aptitude and degree of frankness." Blakiston's Gould Medical Dictionary (3d ed.1972).

word-finding pauses, aphasia, paraphasias, or articulation problems." Dr. Smith's clinical impression was that Mr. Kearney was in the "superior" intelligence range. When he gave Mr. Kearney pencil and paper tests, his intelligence scored as average on at least one test, extremely high on another, and his memory as "superior" and "unimpaired." His MMPI was normal. Dr. Smith noticed in Dr. Lehman's records that Mr. Kearney had complained of memory problems at least once in the early 1980's, while he was still active as a trial lawyer and long prior to his claim, and again in mid-1992 before his bypass surgery. "In essence," Dr. Smith concluded, "on formal testing I could find no evidence of cognitive deficiencies."

Mr. Kearney challenged Dr. Smith's conclusion that there was nothing wrong with his intellect or memory with a letter by Robert M. Bittle, M.D., a psychiatrist and neurologist. Dr. Bittle had examined Mr. Kearney for two hours, and had looked at Dr. Smith's report and at another psychologist's report Mr. Kearney's attorney gave him from a Dr. Fulton, which is not in the record. Dr. Bittle opined that Dr. Smith's foundation for his conclusions was inadequate, because there were some additional intelligence tests he should have given. Dr. Bittle says that the "raw data" from Dr. Fulton's tests in Dr. Bittle's opinion showed cognitive and memory deficits. Dr. Fulton's test data are not in the record. Dr. Bittle's own mental-status examination showed that Mr. Kearney's "estimated intelligence overall is superior," but he also observed "some immediate memory and concentration problems." Dr. Bittle wrote that "post-operative cognitive dysfunction and deficiencies with memory and concentration problems" are common

complications from open-heart surgery, and while they usually clear up, sometimes they do not. Dr. Bittle opined that "it is highly medically probable that Mr. Kearney's memory/concentration and cognitive deficits do interfere significantly with his ability to function in the highly complex arena as a trial attorney."

Standard asked Dr. Smith to review Dr. Weinreb's and Dr. Bittle's letters and reassess his own opinion in light of them. Dr. Smith said he did the tests appropriate to Mr. Kearney's description of his problems, as opposed to those he might do after a head injury, and that doing the additional tests suggested by Dr. Bittle would be like doing a leg x-ray on someone with no symptoms in his leg. Mr. Kearney scored in the 98th percentile on analytic tasks, and showed minimal memory deficit which could result from psychological factors as well as hypothesized edema or hypoxia during heart surgery. He maintained his opinion that Mr. Kearney could resume work as an attorney "even in a trial setting." Dr. Smith noted, however, that he had not been furnished with the "raw test data" from Dr. Fulton that Dr. Bittle reported receiving from Kearney's attorney.

Based on this record, we conclude that there was a genuine issue of fact as to whether Kearney was disabled in the sense defined by the policy. Such evidence as Dr. Smith's and Dr. Heublein's could justify a reasonable trier of fact in concluding that Mr. Kearney's memory and intellect were unimpaired, and his car racing and intense tennis playing could justify the conclusion that he could handle the mental and physical demands of trial work. On the other hand, such evidence as Dr. Bittle's and Mr.

Kearney's could justify the conclusion that Mr. Kearney's memory and intellect disabled him from trial work, and Dr. Weinreb's report could justify the conclusion that Mr. Kearney could no longer handle the stress of trial work.

Because the record establishes a genuine issue of fact as to whether Mr. Kearney was disabled under the terms of the policy, we must reverse the summary judgment.

Mr. Kearney also argues that the district court should not have used only the "unable to perform your specialty" definition of disability, and that it should have also considered the "unable to earn more than 80%" of predisability earnings definition. Because Mr. Kearney did not challenge Standard's use of the "unable to perform" subsection in district court until his motion to vacate the judgment, he cannot challenge it for the first time on appeal.

Mr. Kearney also challenges the attorneys' fees award made against him pursuant to 29 U.S.C. § 1132(g)(1). See Estate of Shockley v. Alyeska Pipeline Serv. Co., 130 F.3d 403 (9th Cir.1997). Because the district court judgment is vacated anyway, on account of the genuine issue of fact established by the record, the district court will necessarily revisit the issue of attorneys' fees after the case is concluded and exercise its discretion in the different circumstances then existing. We accordingly need not reach the issue.

IV. Remand.

Because the summary judgment is reversed because of a genuine issue of fact, the genuine issue of fact must be

resolved by trial. But there is a complexity, because this is an ERISA case. If the trial starts from scratch, and any evidence is admissible whether it was furnished to the administrator or not, then the effect of a genuine issue of fact is to change the question. Instead of de novo review testing whether the individual was entitled to benefits based on the evidence before the administrator and such other evidence as might be admissible under the restrictive rule of Mongeluzo, "review" would be converted into a trial de novo based on evidence entirely unrestricted by what had been presented to the administrator.

The statute adopts a policy "to increase the likelihood" that beneficiaries "will receive their full benefits" and "to maintain the premium costs of such system at a reasonable level." 29 U.S.C. § 1001b(c)(3),(5). The procedure the statute requires for disputed claims includes "a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim." 29 U.S.C. § 1133(2). The Supreme Court has reminded us of "the public interest in encouraging the formation of employee benefit plans" and also "the need for prompt and fair claims settlement procedures." Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 54, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987).

A full trial de novo in any ERISA dispute where there was a genuine issue of fact as to whether the individual qualified for a benefit would undermine these policies. Trial de novo on new evidence would be inconsistent with reviewing the administrator's decision about whether to

grant the benefit. The means that suggests itself for accomplishing trial of disputed facts, while preserving the value of the fiduciary review procedure, keeping costs and premiums down, and minimizing diversion of benefit money to litigation expense, is trial on the administrative record, in cases where the trial court does not find it necessary under Mongeluzo to consider additional evidence.

Although Rule 43(a) requires that "testimony" be taken in open court, the record should be regarded as being in the nature of exhibits, in the nature of documents, which are routinely a basis for findings of fact even though no one reads them out loud. We have affirmed bench trials on records in other cases. See Adair v. Sunwest Bank (In re Adair), 965 F.2d 777, 779 (9th Cir.1992). A majority of us conclude that, in its discretion guided by Mongeluzo, the district court may try the case on the record that the administrator had before it.[4] This is vastly less expensive to all parties, accomplishes the policies enacted as part of the statute, and also gives significance, which would otherwise largely evaporate, to the administrator's internal review procedure required by the statute.

Is there any point in remanding for such a trial, considering that the district judge may read exactly what

4. The author of this opinion writes with some trepidation about this novel form of trial. But it is more important that the law on a matter involving large numbers of transactions be clear and settled, than that each judge's personal views be articulated separately. As a practical matter, we have a majority for the view expressed in this section, and it is essential to claimants, administrators, and employers who fund ERISA plans, as well as district judges, that they have some authoritative statement of the law that they can safely apply.

he has already read, which did not persuade him that Mr. Kearney could establish even a genuine issue of fact as to whether he was disabled? A majority of us concludes that there is.[5] The district judge will be asking a different question as he reads the evidence, not whether there is a genuine issue of material fact, but instead whether Mr. Kearney is disabled within the terms of the policy. In a trial on the record, but not on summary judgment, the judge can evaluate the persuasiveness of conflicting testimony and decide which is more likely true. The difference in the questions he is asking of the material may lead the judge to read it differently. The district judge will retain discretion to decide, subject to Mongeluzo, whether, in order to answer this different question, he should take additional evidence. "[T]here is no such thing as . . . findings of fact, on a summary judgment motion." Thompson v. Mahre, 110 F.3d 716, 719 (9th Cir.1997). But in a bench trial on the record, the judge will have to make findings of fact under Federal Rule of Civil Procedure 52(a). The process of finding the

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5. Judge Silverman's concurrence and Judge Fernandez's dissent suggest that a remand is a waste of time, because the district judge has already evaluated the evidence and would merely be engaging in an empty formality to reach the same conclusion. That is a reasonable concern. But we currently are divided about whether the district judge's decision was correct on the evidence before him. Some of us think that the evidence before the administrator did not amount to satisfactory proof of disability. Some of us think that it did. This difference of opinion about whether there was satisfactory proof of disability establishes the desirability of having a trier of fact decide what the evidence proved. This kind of question, what the evidence proved as opposed to whether there was a genuine issue of fact, is ordinarily committed for decision to trial courts, not appellate courts.

facts "specially," as that rule requires, sometimes leads a judge to a different conclusion from the one he would reach on a more holistic approach. Also, it completely changes our authority on review, from de novo review of summary judgment, to clearly erroneous review of findings of fact.[6] That change could be outcome determinative. Thus trial on the record, even if it consists of no more than the trial judge rereading what he has already read, and making findings of fact and conclusions of law instead of a summary judgment decision, may have real significance.

Conclusion.

Though we conclude that the district court was correct as to its scope of review, de novo, and within its discretion in limiting the scope of the evidence to what was before the administrator, we nevertheless must REVERSE because on de novo review of the summary judgment, we conclude that there is a genuine issue of material fact. Accordingly, we REMAND for trial consistent with this opinion.

No costs.

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6. Judge Reinhardt argues that this discussion of standard of review is dicta, and suggests that the standard of review may be de novo. The reason why standard of review is discussed is that it is among the reasons why remanding for findings of fact is more than an empty formality. As for what it is, we have in numerous prior cases held that when a district judge tries a case on a written record without live testimony and makes findings of fact, "we apply the 'clearly erroneous' rule, Fed.R.Civ.P. 52(a) in reviewing the judge's findings." See, e.g., Starsky v. Williams, 512 F.2d 109, 111 (9th Cir.1975); Wolfe v. United States, 798 F.2d 1241, 1243 n. 2 (9th Cir.1986); EEOC v. Maricopa County Community College District, 736 F.2d 510, 513 (9th Cir.1984).

Appendix A

FLETCHER, Circuit Judge, concurring in part and dissenting in part from Judge Kleinfeld's plurality opinion, and concurring in full in Judge Silverman's opinion:

Although I concur in Judge Silverman's opinion, in light of the fragmented views of the court, I must say more. Apparently the case will be remanded to the district court. A majority of the court agrees that the district court got it wrong in one respect or another and must reconsider.

The majority agrees that the district court's review must be de novo. The district court labeled its review de novo, and purported to review only for summary judgment. However it then proceeded to weigh the evidence and reach a decision on the merits, rather than to determine only whether material issues of disputed fact existed. Now the majority returns the case to the district court to do it again.

Let us disabuse the district court that its role is to grant or deny summary judgment. A district court, in a case that requires de novo review of the denial of ERISA benefits, is performing a different function. First, it must determine whether the record made before the administrator is adequate. Either on the record that was before the administrator or after admitting additional evidence, the district court then reviews the claim on the merits. It should review a record that is sufficiently developed "to enable the full exercise of informed and independent judgment." Mongeluzo v. Baxter Travenol Disability Ben. Plan, 46 F.3d 938, 943 (9th Cir.1995). Summary judgment, in contrast, is a vehicle for the timely disposition of cases as a matter of law. The exercise is to determine whether there are

disputes of material fact that necessitate trial. See FED. R. CIV. P. 56 advisory committee's note. In the ERISA context, where the review is de novo, the issue is not whether judgment as a matter of law is appropriate, but whether additional evidence is required to enable the district court to render an informed decision on an adequate record. Such evidence should be received by whatever means is appropriate (live testimony or affidavits, for example). Once the record is sufficiently developed, the district court should render its decision to grant or deny benefits. The district court makes whatever factual findings are necessary and rules on the claim for benefits.

Since the majority insists the case is going back, the district court must start fresh. It must follow the dictates of Mongeluzo and must see that the record is developed fully "to enable the full exercise of [its] informed and independent judgment." Mongeluzo, 46 F.3d at 943.

Appendix A

REINHARDT, Circuit Judge, concurring in the result:

Judge Silverman's argument that Kearney is entitled to summary judgment on the current record is extremely persuasive, and I cannot disagree with his analysis. However, although the question is a close one, I conclude that the litigation may benefit from a trial on the merits. Given the absence of evidence in the record regarding the duties of a trial attorney, as well as the uncertain and conflicting nature of some of the medical evidence, a genuine issue of material fact may well remain as to whether Kearney's limitations disabled him from his "specialty" in the practice of law.

While I can concur in the decision to remand for a trial and in Section I of what Judge Kleinfeld contends is a majority opinion, I unfortunately cannot concur in the remainder of that opinion. At places, the opinion appears to me to be unclear or uncertain and, as a result, is susceptible of conveying an inaccurate message. In other places, it contains dicta that is not only unnecessary but incorrect. In addition, I disagree with some of Judge Kleinfeld's legal and philosophical conclusions, such as his statement that a conflict existed between Kearney and Snow[1]

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1. In fact, there was no such conflict. Conflicts exist between opinions, not between the arguments and briefs of the parties. There is no conflict between the two opinions because while the Kearney panel opinion, like Judge Kleinfeld's en banc opinion, carefully sets forth and construes the specific language of a policy provision, no policy provision is set forth in Snow, and the Snow opinion therefore contains no construction of any identifiable policy

. (Cont'd)

and that a less "holistic" approach may be the solution to our problem.

I also agree with Judge Fletcher's characterization of Judge Kleinfeld's opinion as a plurality opinion, at least with respect to Parts III and IV. I do not think that votes by dissenting judges can be used to make a plurality opinion a majority one. Judge O'Scannlain has joined the dissenting opinion but also seeks to concur separately in Parts III and IV. His effort does not change the status of Judge Kleinfeld's opinion.

Rather than try to identify the precise statements in Judge Kleinfeld's opinion with which I agree or disagree, I will try to restate what I believe our remand means. Let me begin by saying that our remand does not limit the discretion of the district court to consider evidence outside the administrative record or recommend that the district judge decline to accept evidence that supplements that record. We simply restate the rule of Mongeluzo v. Baxter Travenol Long Term Disability Benefit Plan, 46 F.3d 938 (9th

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(Cont'd)
language, regardless of what the parties' briefs represent about the underlying facts of that case. Cf. Kearney v. Standard Ins. Co., 144 F.3d 597, 601 (9th Cir.1998), reh'g granted, opinion withdrawn by 152 F.3d 1098 (9th Cir.1998) with Snow v. Standard Ins. Co., 87 F.3d 327, 330 (9th Cir.1996). As Section I of Judge Kleinfeld's opinion makes clear, it is the precise language of the policy that is critical when we attempt to analyze the legal issues involved in determining coverage. For that reason, contrary to Judge Kleinfeld's earlier statement, Snow was of little or no precedential value, and Kearney was indisputably not in conflict with it.

Cir.1995), and hold that the district court did not abuse its discretion under that standard at the time of the summary judgment proceeding. Given that, in the summary judgment proceeding, Kearney offered in evidence only a brief definition from the Occupational Outlook Handbook and failed to specify any additional medical evidence he sought to offer beyond that already in the record before the administrator, I do not disagree with the conclusion that, for the purposes of summary judgment, the district court correctly limited the evidence to that record.

Obviously, we cannot issue rulings at this stage of the proceedings on the admissibility of evidence not yet presented to the district court, just as we cannot rule in advance on the standard of review that will be applied if the district court's decision on the merits after trial becomes the subject of a future appeal. At trial, the district court will face a new and very different problem (even though the ultimate question, whether in view of his physical and mental limitations Kearney can properly continue to practice his specialty as a trial lawyer, remains the same). Judge Kleinfeld's opinion acknowledges that we are not ruling in advance on the admissibility of any additional evidence that the parties may seek to present at trial; that the district court will now be required to make findings of fact and answer a different question in its review of the record; and that the district court "will retain discretion to decide, subject to Mongeluzo, whether, in order to answer this different question, he should take additional evidence." Kleinfeld Op. at 3890-91.

Of course, we cannot predict what additional evidence Kearney will submit and whether such evidence will meet Mongeluzo 's standard. Kearney may offer evidence regarding the duties of a trial attorney that the district court finds more useful than the brief definition contained in the Occupational Outlook Handbook. He may also offer specific medical evidence that could not have been presented to the plan administrator. Kearney may also seek to offer other additional evidence that he did not believe necessary at the time Standard was considering his claim, but that would be pertinent at time of trial. And finally, as Judge Kleinfeld's opinion points out, the district court may decide that evidence that was previously unnecessary is now essential for the different kind of review that it will engage in on remand. We simply cannot foresee what the parties will present or argue, and we do not know how the district court will rule on such evidence when it conducts its trial on the merits.

In fact, it is quite clear that additional evidence will be required in order to resolve the question whether Kearney's disability precludes him from performing the material duties of his specialty as a trial lawyer. Even though the district court was within its authority to reject Kearney's evidentiary offer of the Handbook definition, there is a serious gap in the record regarding the duties of a trial attorney. The experience of one judge, which led him to conclude that the need to "avoid severe emotional stress or very hard work does not warrant the conclusion that [Kearney] cannot practice as a trial attorney,"[2] is clearly not sufficient. Those

2. As Judge Kleinfeld's opinion notes, Dr. Weinreb had warned Kearney to avoid "very heavy work and very severe emotional stress" or working on a "very tight time schedule."

of us who have been trial lawyers, particularly those familiar with the obligations of plaintiffs' trial lawyers, and the severe stress involved when one holds the future of an injured client and his family, or indeed a widow and hers, in one's hands, know that emotional stress, time pressure, long hours, a tight time schedule, and extremely hard work are an unavoidable part of trial practice. But rather than relying on his own or any other judge's personal experience, the district court should admit appropriate additional evidence that is offered on this question.

The factors that courts must consider in determining whether to allow additional evidence are set forth in Quesinberry, the case that Mongeluzo followed:

> claims that require consideration of complex medical questions or issues regarding the credibility of medical experts; the availability of very limited administrative review processes with little or no evidentiary record; the necessity of evidence regarding interpretation of the terms of the plan rather than specific historical facts; instances where the payor and the administrator are the same entity and the court is concerned about impartiality; . . . and circumstances in which there is additional evidence that the claimant could not have presented in the administrative process.

Quesinberry v. Life Ins. Co., 987 F.2d 1017, 1026-27 (4th Cir.1993) (en banc) (emphasis added). Kearney's claim turns on the interpretation of a key provision of the plan,

the definition of the "material duties" of a trial attorney. The plan administrator's erroneous conclusion that the nature of a trial attorney's work was "sedentary;" the lack of notice to Kearney that Standard would adopt such an erroneous definition and rely on it in denying his claim; the materiality of this dispute to the resolution of Kearney's claim; the lack of any information in the evidentiary record on this question; and the effect that Standard's conflict of interest may have had on its decision-making; together necessitate the admission of additional evidence on this question at a trial on the merits. See Mongeluzo, 46 F.3d at 944; Quesinberry, 987 F.2d at 1026-27.

I agree with Judge Kleinfeld's conclusion that a full trial de novo is not necessary, and that the district court should begin with the record that was before Standard and then determine what "additional evidence is necessary to conduct an adequate de novo review." Mongeluzo, 46 F.3d at 944. See also Quesinberry, 987 F.2d at 1025. But indeed it would make no sense to remand simply to apply a different and more difficult standard — from the appellant's standpoint — to the identical record.[3] If I believed that the record before the district court was adequate, and that the district court should simply review that record without taking additional evidence, then I would agree with others

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3. Contrary to the optimistic ruminations of Judge Kleinfeld, I believe that a judge who granted summary judgment to the defendant on the record before us would necessarily grant that party judgment on the merits, were he to restrict his review to that record but this time be free to draw all inferences in favor of the defendant rather than the plaintiff.

on both sides that there is absolutely no purpose to a remand. I would then join Judge Silverman's persuasive opinion.

Judge Kleinfeld also includes a brief prediction that, after the district court decides this case on remand, we will review the district court's findings of fact under a clearly erroneous standard, regardless of whether the trial judge admits additional evidence, hears testimony, or merely confines his review to the record that was before the plan administrator. However, we, of course, cannot determine in advance what the standard of review will be for a case that is not before us. If the district court's findings and conclusions are based solely on the record that was before the plan administrator, there is a strong argument that our review need not be so deferential. "District court review of agency action is generally accorded no particular deference, because the district court, limited to the administrative record, is in no better position to review the agency than the court of appeals." Great Western Bank v. Office of Thrift Supervision, 916 F.2d 1421, 1426 (9th Cir.1990) (quoting Asarco, Inc. v. EPA, 616 F.2d 1153, 1161 (9th Cir.1980)). Similarly, "[b]ecause we are in as good a position as the district court to review the findings of the bankruptcy court, we independently review the bankruptcy court's decision." In re Marquam Inv. Corp., 942 F.2d 1462, 1465 (9th Cir.1991) (quoting Matter of Pizza of Hawaii, Inc., 761 F.2d 1374, 1377 (9th Cir.1985)). Likewise in social security disability cases we independently review the administrative law judge's decision. See Sousa v. Callahan, 143 F.3d 1240, 1243 (9th Cir.1998). Were the district court in this instance to limit its review to the record—which it should not—the question whether to afford deference to its factual findings

would be an open one. This, of course, is wholly aside from the question whether the refusal to admit the evidence would be reversible as an abuse of discretion. Because at this stage of the proceedings, we do not even know what it is that we will be reviewing, if anything, any discussion as to the applicable standard of review is, at most, dictum.

O'SCANNLAIN, Circuit Judge, concurring in part and dissenting in part from Judge Kleinfeld's opinion, and joining Judge Fernandez's dissent:

I join in Judge Fernandez's dissent. I write separately only to indicate that, but for my conclusion that the policy conferred discretion upon the plan administrator, I would resolve the remaining issues as did Judge Kleinfeld in parts II, III, and IV of his opinion. I therefore concur in parts II, III, and IV of Judge Kleinfeld's opinion to that extent.

Appendix A

SILVERMAN, Circuit Judge, with whom FLETCHER, Circuit Judge, joins, concurring in part and dissenting in part:

I am pleased to join Parts I and II of the majority opinion. However, I fail to see the point of remanding this case for a "trial" at which the district judge will admit no new evidence, merely re-read the evidence he already read in connection with the cross-motions for summary judgment, and then render a "verdict." He's been there and done that.[1] The only question is whether the information in Standard's possession was — in the language of the plan — "satisfactory." On cross-motions for summary judgment, the district judge ruled that it is not. And that is a question of law, which itself is reviewed de novo on appeal.

With all due respect, the majority gets off the track by latching on to the contradictory evidence of Kearney's condition in Standard's possession, then finding "a genuine question of fact as to whether Kearney was disabled in the

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1. Judge Posner wrote in an analogous situation:

> But because, as we have said, there is no right to a jury trial in an ERISA case . . . , and here no evidence besides that introduced at the summary judgment stage that the parties would be presenting at a trial, all the evidence bearing on the issue of contractual meaning was before the trier of fact at that stage. In these unusual circumstances, to remand the case for trial would be an empty formality; . . .

Mathews v. Sears Pension Plan, 144 F.3d 461, 468 (7th Cir.1998).

sense defined by the policy." In my view, the question at this stage is not whether Kearney is disabled. The question is whether the evidence of disability in Standard's possession was "satisfactory." Either it was or it wasn't. There is no dispute over what information Standard possessed. The only question is whether it was sufficient. That is the question to be reviewed de novo.

There are no factual disputes. In their cross-motions for summary judgment, the parties recognized this and so did the judge. Although Kearney and Standard disagree over the legal conclusions to be drawn from the written information that Standard had received, there is no disagreement over what it had received. It is "satisfactory" or it isn't.

The plan administrator doesn't conduct a trial. It pays or denies plan benefits on basis of the information in its possession, even if some of it is contradictory. In reviewing Standard's decision de novo, we are in the same boat. Mongeluzo v. Baxter Travenol Long Term Disability Benefit Plan, 46 F.3d 938, 943 (9th Cir.1995). It is true that in an ERISA case, additional evidence can be received in the course of judicial review to supplement what was presented to the administrator. However, whether to allow supplementary evidence is a matter wholly within the discretion of the district judge. Id. at 943-944. I agree with the majority that the district judge did not abuse his discretion in declining to receive new evidence. But, with no new evidence to consider, that leaves us where we started: de novo review of whether the proof of disability in Standard's possession was "satisfactory." That was the

legal question before the district court on cross-motions for summary judgment, the question on which it ruled in favor of Standard, and where the district judge and I part company.

In my view, Kearney's motion for summary judgment should have been granted and Standard's denied. Rather than repeat it here, I commend the reader to Judge Reinhardt's powerful description of the cogent evidence Kearney submitted to prove his disability. Kearney v. Standard Ins. Co., 144 F.3d 597, 600-603 (9th Cir.) rehearing granted, opinion withdrawn, 152 F.3d 1098 (1998). It is also true that Standard was in possession of information that suggested otherwise. Of course, the insurance company must not be made to pay for losses that are not covered by the plan or for claims that have not been proven. But in cases such as this one, where there is strong evidence of a covered loss, some evidence to the contrary, and no definitive way to know for sure, the benefit of the doubt should have been resolved in favor of the beneficiary. For that reason, viewing it on a de novo basis, I would have found Kearney's proof of disability to be "satisfactory" in light of the totality of the evidence in Standard's possession.

Accordingly, I would reverse the district court with directions to grant Kearney's motion for summary judgment and deny Standard's.

Appendix A

FERNANDEZ, Circuit Judge, with whom O'SCANNLAIN, and T.G. NELSON, Circuit Judges, join, dissenting.

While I see no particular point in disputing the majority's determination that this case must be remanded to the district court,[1] I do not concur with its rationale, reasoning or result. Hence I dissent because, as I see it, the keystone of the approach favored of the majority is undue caution about treating administrator authority under an ERISA plan different from insurance company authority in the non-ERISA insurance world. However, because that keystone is defective, the whole arch of the opinion must collapse. There are two major fractures in that most important voussoir.

The first fracture exists because there is no need for such great caution. This case does not involve a mere contract; it involves an ERISA plan. The difference is exceedingly important and imposes both benefits and burdens upon any entity which is acting as an administrator of a plan. For Standard, and for all other similarly situated companies, the fiduciary nature of the duties can be a double-edged sword to say the least.

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1. Under either of our approaches, the district court failed to apply the proper standards when it decided this case. Although it is a bit difficult to see how the district court would be inclined to reach a different result on an abuse of discretion standard, I see no need to spill ink applying that standard to the facts of this case in light of the decision that the case will be returned to the district court to apply the even stricter de novo standard.

In an ordinary contract case, for example, one party is not a fiduciary for the other. Even insurance is simply a special kind of contract between two consenting parties. See, e.g., Hassard, Bonnington, Roger & Huber v. Home Ins. Co., 740 F.Supp. 789, 791-92 (S.D.Cal.1990); Lunsford v. American Guarantee & Liab. Ins. Co., 775 F.Supp. 1574, 1583 (N.D.Cal.1991); Love v. Fire Ins. Exch., 221 Cal.App.3d 1136, 1147-50, 271 Cal.Rptr. 246, 252-54 (1990); Henry v. Associated Indem. Corp., 217 Cal.App.3d 1405, 1418-19, 266 Cal.Rptr. 578, 586 (1990). That fact means that parties can be expected to, and do, deal with each other at arms length to some extent. Special doctrines do hedge, or erode, the full impact of the somewhat theoretical assumption of a true negotiation between large insurance companies and ordinary consumers. Thus, the covenant of good faith and fair dealing is implied, as it is in all contracts, but it is heightened in the insurance context and a violation of it can lead to tort liability. See e.g., Love, 221 Cal.App.3d at 1147-48, 271 Cal.Rptr. at 252-53. Nonetheless, an insurance company, like anyone else, can pursue its own interests, as long as it does not violate the terms of its contract (including the covenant of good faith). As a result, we might well feel great trepidation about finding that a contracting party has discretion, and might be quite chary about bestowing a discretionary interpretation upon the words of an insurance, or other normal, contract.

When it comes to ERISA, however, we cannot simply apply the same premises, even when an insurance company is involved. The whole arrangement is quite different when a company undertakes to act as a plan administrator. It, then, is not a mere contracting party; it is a fiduciary. See 29

U.S.C. §§ 1002(16)(A), 1002(21)(A). In effect, the entity creating the plan is a trustor, the administering company is a trustee, and the claimant is a beneficiary of that trust. Therefore, even though it does insure a benefit, an insurance company must act as a fiduciary must act. That actually imposes a higher duty upon it than it would undertake were it in a mere contractual relationship. It cannot simply act as a self-interested party that need only avoid violating the legal floor created by the covenant of good faith and fair dealing. It must reach much higher; it must act with the very punctilio of fairness. See 29 U.S.C. § 1104(a)(1) ("[A] fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries. . . ."); NLRB v. Amax Coal Co., 453 U.S. 322, 329, 101 S.Ct. 2789, 2794, 69 L.Ed.2d 672 (1981) ("[A] trustee bears an unwavering duty of complete loyalty to the beneficiary of the trust, to the exclusion of the interests of all other parties."); Blau v. Del Monte Corp., 748 F.2d 1348, 1353 (9th Cir.1984) ("The administrator of an employee welfare benefit plan . . . has no discretion . . . to flout the . . . fiduciary obligations imposed by ERISA, or to deny benefits in contravention of the plan's plain terms."); Restatement (Second) of Trusts § 170(1)(1959) ("The trustee is under a duty to the beneficiary to administer the trust solely in the interest of the beneficiary."); Restatement (Second) of Trusts § 183 (1959) ("When there are two or more beneficiaries of a trust, the trustee is under a duty to deal impartially with them."); cf. Howard v. Shay, 100 F.3d 1484, 1488 (9th Cir.1996) (The administrator's "duties are the 'highest known to the law.' ").

At the same time, it is not at all unusual to confer discretion upon a trustee; it is rather normal so to do. Thus, while it might seem a bit jarring to interpret ordinary contract language in a way that confers discretion, where one party must depend on the mere good faith of the other, it is not at all surprising to find discretionary language in an ERISA plan, where the beneficiary can insist on fiduciary behavior. In the former case, the conferral of discretion may seem downright scary; in the latter, the principles of trust law act as an anodyne for undue fears. It is true that when there is discretion courts will only review the administrator's actions for an abuse of that discretion. See Restatement (Second) of Trusts § 187 (1959). However, the high principles and standards of trust law do protect the beneficiary. No fiduciary, not even an insurance company, can draw much comfort from the fact that discretion is conferred upon it, if it acts in a lax, conflicted, arbitrary, capricious, or abusive manner toward the beneficiary.[2]

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2. Of course, just when a conflict will be found is not part of the determination of whether there is discretion in the first place. Because the disposition of this case by the majority—the determination that requires us to use a de novo standard—turns on the conferral issue, there is no real point in exploring the conflict standard at this juncture. We have spoken to it in the past. See Atwood v. Newmont Gold Co., Inc., 45 F.3d 1317, 1322-23 (9th Cir.1995); see also Lang v. Long-Term Disability Plan of Sponsor Applied Remote Tech., Inc., 125 F.3d 794, 798 (9th Cir.1997). Other courts have also done so in varying ways and with varying results. See, e.g., Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan, 144 F.3d 1014, 1020 (7th Cir.) cert. denied, __ U.S. __, 119 S.Ct. 372, 142 L.Ed.2d 307 (1998); Doyle v. Paul Revere Life Ins. Co., 144 F.3d 181, 184 (1st Cir.1998).

Nevertheless, trust law principles do not cut in only one direction. The beneficiary is left to the mercy of the trustee, as long as the trustee does not violate the duties imposed upon him. That uncovers the second fracture in a timorous approach — the treatment of ERISA as if it were a one-way statute.

ERISA was intended to protect beneficiaries, but that is not all it was intended to do. There might not be a beneficiary to protect, if employers and plan administrators were faced with constant litigation and expense when they set up their plans. Myriads of state laws, proliferating concepts of state tort liability (insurance bad faith cases for example), and litigious delays, could all conspire to make the very setting up of ERISA plans decidedly unattractive to many employers. Transaction costs, like litigation and constant judicial "refinements" over the course of hundreds of disputes, will not always enhance the efficient delivery of benefits. Thus, as we have said, "ERISA was enacted to promote and protect employer interests as well as employee interests." Aloha Airlines, Inc. v. Ahue, 12 F.3d 1498, 1503 (9th Cir.1993). Moreover, ERISA does "set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans." Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 54, 107 S.Ct. 1549, 1556, 95 L.Ed.2d 39 (1987).

Once all of this is realized, we may take heart, become more robust, and discover that we need not strain ourselves to assure that federal courts will give a meticulous de novo

review to as many ERISA decisions as possible, either because we think of insured ERISA plans as being much like ordinary contracts or because we believe that ERISA was single-mindedly directed to the maximization of each employee's recovery from available plans. That explains why, as we pointed out in Snow v. Standard Ins. Co., 87 F.3d 327, 330 (9th Cir.1996), "[w]e have not been stingy in our determinations that discretion is conferred upon plan administrators."

Of course, timidity aside, the first step in our analysis must still be to determine whether "the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115, 109 S.Ct. 948, 956-57, 103 L.Ed.2d 80 (1989). If it does not, review is de novo. If it does, we should, instead, review the decision for abuse of discretion. See Snow, 87 F.3d at 330; Atwood, 45 F.3d at 1321 & n. 1; McKenzie v. General Tel. Co., 41 F.3d 1310, 1314 (9th Cir.1994); Taft v. Equitable Life Assurance Soc'y, 9 F.3d 1469, 1471 & n. 2 (9th Cir.1994). We outlined the general principles which should be applied to that determination in Snow, 87 F.3d at 330, and, as I see it, there is no reason to deviate from that outline at this time. We said:

> [A] proper and efficient functioning of an ERISA plan does often depend upon the use of discretion by the plan fiduciaries. As we have pointed out, a plan does confer discretion when it "includes even one important discretionary element, and the power to apply that element is

> unambiguously retained by its administrator." Bogue v. Ampex Corp., 976 F.2d 1319, 1325 (9th Cir.1992), cert. denied, 507 U.S. 1031, 113 S.Ct. 1847, 123 L.Ed.2d 471 (1993). In Bogue that element was found in language in an employment severance plan which provided that the administrator would make determinations about similar employment positions within the company. Id. at 1324. In other words, if the plan administrator has the authority to determine eligibility for benefits, that inherently confers discretion upon him. See Patterson v. Hughes Aircraft Co., 11 F.3d 948, 949-50 (9th Cir.1993) (per curiam); Eley v. Boeing Co., 945 F.2d 276, 278 (9th Cir.1991); Madden v. ITT Long Term Disability Plan for Salaried Employees, 914 F.2d 1279, 1284-85 (9th Cir.1990), cert. denied, 498 U.S. 1087, 111 S.Ct. 964, 112 L.Ed.2d 1051 (1991).

Id.

The plan in this case required that the beneficiary supply "satisfactory written proof" to Standard. In my opinion, that does not require a construction different from the one we reached in Snow, where we said:

> The plan before us provides that there will be no benefit payment unless Standard is presented with what it considers to be satisfactory written proof of the claimed loss. We see no relevant difference between that and plans which declare

> that the plan administrator will determine eligibility. It is apparent that both require the administrator to decide whether the person has become eligible as a result of presentation of satisfactory proof to that effect. See Donato v. Metropolitan Life Ins. Co., 19 F.3d 375, 378-80 (7th Cir.1994); Miller v. Metropolitan Life Ins. Co., 925 F.2d 979, 983-84 (6th Cir.1991); Bali v. Blue Cross & Blue Shield Ass'n, 873 F.2d 1043, 1047 (7th Cir.1989). Therefore, the district court correctly determined that review of Standard's decision must be for an abuse of discretion.

Id. (footnote reference omitted). I recognize that saying "proof which is satisfactory" can be distinguished from saying "proof which is satisfactory to us." However, aside from nice scholastic debates, it is a distinction without a difference, unless, based upon some of the ephemeral concerns upon which I have already expatiated, we desire to limit the conferral of discretion as much as we can.

The Sixth Circuit put its finger on the issue and the lack of a true distinction, when it said:

> Although many of our prior cases finding a clear grant of discretion involved ERISA plans which explicitly provided that the evidence be satisfactory "to the insurer," "to the company" or "to us," it does not automatically follow in the absence of such language discretion has not been granted to the plan administrator. . . . We

> agree with Aetna that this "right to require as part of the proof of claim satisfactory evidence" means, semantically, that the evidence must be satisfactory to Aetna, the only named party with the right to request such evidence. It naturally follows that Aetna, the receiver of the evidence, would review that evidence to determine if it constitutes satisfactory proof of total disability. It is simply implausible to think that Aetna would merely hold the evidence as a safe keeper or depository for a third party unnamed in the contract to review in making benefits determinations.

Perez v. Aetna Life Ins. Co., 150 F.3d 550, 556-57 (6th Cir.1998). Just so. Our normal generous approach to the finding of discretion should dictate that Standard had discretion here.

Moreover, as far as the doctrine of contra proferentem is concerned, I am dubious about its application to the determination of whether discretion has been conferred upon an ERISA plan administrator, as opposed to its application to the construction of coverage and exclusion terms in a plan involving insurance. But even if it did properly apply, I see no significant ambiguity in the language at hand. Cf. Kunin v. Benefit Trust Life Ins. Co., 910 F.2d 534, 538-41 (9th Cir.1990). It is true that omission of the phrase "to us" does allow sophisticated linguists to argue that there is no discretion, even if discretion would otherwise exist. It is also true that sophisticated judges can make sophisticated alternative and competing arguments. That, to my mind, is

not enough to create true ambiguity. Ambiguity has never meant that courts or judges differ. Were it so, conflicting rulings would always require a finding of ambiguity, which definitely is not the case. See, e.g., New Castle County v. Hartford Accident and Indem. Co., 933 F.2d 1162, 1195-96 (3d Cir.1991) (presence of conflicting judicial decisions does not mandate a finding of ambiguity); ACL Techs., Inc. v. Northbrook Property & Cas. Ins. Co., 17 Cal.App.4th 1773, 1787 n. 39, 22 Cal.Rptr.2d 206, 214 n. 39 (1993) (disagreement among judges of different jurisdictions does not establish ambiguity); Lower Paxton Township v. United States Fidelity & Guar. Co., 383 Pa.Super. 558, 573 n. 4, 557 A.2d 393, 400 n. 4 (1989) (ambiguity is not found by the mechanical process of searching for conflicting court decisions). Thus, I do not think that we should be bewitched, bothered or bewildered by those levels of sophistication. In "an ordinary and popular sense" there can be little doubt that it was the administrator to whom the proof had to be satisfactory. Perez, 150 F.3d at 556. Equally, there can be little doubt that in the ERISA fiduciary world the satisfaction reaches the whole of the decision.

I recognize that it can be argued that the word "satisfactory" does not convey any hint of discretion, whether it is followed by the phrase "to us" or not. That seems plainly wrong. Of course, the idea of discretion does not connote limitless power. If there are objective limits to discretion, as there are in anything but the strangest circumstances, that does not detract from its existence. Discretionary decision-making does not mean standardless decision-making. See, e.g., Cooter & Gell v. Hartmarx Corp., 496 U.S. 384, 405, 110 S.Ct. 2447, 2461, 110 L.Ed.2d

359 (1990) (discretion abused on erroneous view of law or clearly erroneous assessment of evidence). Even referees, whose game calls are unappealable, do not act in a standardless world.

We should decide that a requirement of satisfactory proof gives the administrator the discretion to determine whether the claimant is entitled to benefits. We should then only patrol the periphery to assure ourselves, and beneficiaries, that there has not been arbitrary, capricious, or conflicted decision making. Absent that, we should let the administrator's decision stand.

A final word on parsing: In this case, the district court decided that it would conduct de novo review, but that it would rely upon the record that was before the plan administrator, rather than receive new evidence. I agree with the majority that the district court did not abuse its discretion when it did that. See majority opinion at pages __ - __; see also Mongeluzo v. Baxter Travenol Long Term Disability Benefit Plan, 46 F.3d 938, 943-44 (9th Cir.1995). So far, so good. At that point, as I see it, the district court should have conducted a trial proceeding in which the trial record consisted of the information which was before the administrator, and should then have considered arguments regarding that record.

Here the district court mislabeled what it was doing when it called the proceeding a summary judgment, and that mislabeling has induced full scale de novo review. Had the district court used the correct label, I would suppose that we would be reviewing its factual determinations for clear error, just as we would in an appeal from any other

trial. See Russian River Watershed Protection Comm. v. City of Santa Rosa, 142 F.3d 1136, 1140-41 (9th Cir.1998); Snow, 87 F.3d at 331. But, then, it is not too surprising when an appellate court decides to rely upon the label given to a proceeding by the district court. In fairness to the district court, however, we (and others) have previously recognized that a summary judgment based on a detailed stipulated record, which this ERISA record amounts to, can result in what is essentially a trial with review of factual determinations for clear error. See Acuff-Rose Music, Inc. v. Jostens, Inc., 155 F.3d 140, 142-43 (2d Cir.1998); Wolfe v. United States, 798 F.2d 1241, 1243 n. 2 (9th Cir.1986); EEOC v. Maricopa County Community College Dist., 736 F.2d 510, 512-13 (9th Cir,.1984); Starsky v. Williams, 512 F.2d 109, 111 (9th Cir.1975). Thus, we have seen that we need not be mesmerized by labels. Also, although epiphanies do happen, I doubt that a judge who cannot even discover a basis in the evidence from which a reasonable trier of fact could find in favor of a party might still decide in that party's favor based on the same evidence. But let that be; at least after today's didactic exercise a district judge will be able to incant canorous phrases which will please our ears.

In fine, I resile from turning ERISA decision making into an aeonian logomachy. I would, instead, allow administrators, who have satisfactory-proof discretion, to make benefit determinations unmolested by court battles, other than those that they bring upon themselves when they violate the requirement that they act as fiduciaries for, rather than as contractual adversaries of, their beneficiaries.

Thus, I respectfully dissent.

APPENDIX B — ORDER OF THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT DATED AUGUST 3, 1998

Rex T. KEARNEY, Jr.,
Plaintiff-Appellant,
v.
STANDARD INSURANCE COMPANY,
Defendant-Appellee.
Rex T. KEARNEY, Jr.,
Plaintiff-Appellant,
v.
STANDARD INSURANCE COMPANY,
Defendant-Appellee.

Nos. 96-16539, 96-16701.

United States Court of Appeals,
Ninth Circuit.

Aug. 3, 1998.

HUG, Chief Judge.

Upon the vote of a majority of nonrecused regular active judges of this court, it is ordered that this case be reheard by the en banc court pursuant to Circuit Rule 35-3. The three-judge panel opinion, Kearney v. Standard Insurance Company, 144 F.3d 597 (9th Cir.1998), is withdrawn.

APPENDIX C — OPINION OF THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT DATED AND DECIDED APRIL 21, 1998

Rex T. KEARNEY, Jr.,
Plaintiff-Appellant,
v.
STANDARD INSURANCE COMPANY,
Defendant-Appellee.
Rex T. KEARNEY, Jr.,
Plaintiff-Appellant,
v.
STANDARD INSURANCE COMPANY,
Defendant-Appellee.

Nos. 96-16539, 96-16701.

United States Court of Appeals,
Ninth Circuit.

Argued and Submitted Aug. 5, 1997.

Decided April 21, 1998.
As Amended May 19 and June 3, 1998.

* * *

Before: SNEED, FLETCHER, and REINHARDT, Circuit Judges.

REINHARDT, Circuit Judge:

Plaintiff-appellant Rex T. Kearney, Jr. is an attorney who was a civil trial partner, and managing partner, at the

law firm of Ingoglia, Marskey & Kearney. In 1992, following open heart surgery, he began receiving disability benefits under a Long Term Disability Plan issued by Defendant-Appellee Standard Insurance Company. Within two years of approving such benefits, however, Standard terminated them. Kearney eventually brought suit under the Employment Retirement Income Security Act (ERISA), 29 U.S.C. § 1132(a)(1)(B) (1994), but the district court granted summary judgment in favor of Standard primarily because in its view "the fact that [Kearney] should, like most of us, avoid severe emotional stress or very hard work does not warrant the conclusion that he cannot practice as a trial attorney." We find both the district court's "diagnosis" and its conclusion very much open to question. Therefore, we reverse and remand.

BACKGROUND

Because we must review this case de novo,[1] we set forth the facts in some detail.

Rex Kearney regularly worked long hours trying civil lawsuits until he encountered health problems. As a trial attorney, a large part of Kearney's success was due to his ability to work very hard while retaining excellent cognitive and verbal skills, often under severe pressure. Indeed, one doctor described him as having a classic "Type A" personality — a frequently obsessive, compulsive worker. On November 3, 1992, however, Kearney — who had already suffered a heart attack in 1981 at the age of 43 and undergone angioplasty of the diagonal artery in 1988 —

1. See infra Part I.

experienced chest pain and nearly collapsed in court during a trial. Six days later, Kearney underwent five-vessel coronary bypass surgery, mitral valve repair, and a closure of a patent pinhole in his heart muscle.

About a month after the surgery, Dr. Stephen Morrison, a Board Certified cardiologist, examined Kearney and noted that he was experiencing musculoskeletal symptoms which should resolve in the next several weeks. Dr. Morrison added, however:

> I am also concerned about his memory and I am [sic] told him that I am impressed that this occurs frequently after bypass surgery, and I am hopeful that this will also significantly improve as it is a very large part of his occupation to have a very adequate and perhaps excellent memory as he is a practicing attorney.

Kearney forwarded this letter and a request for disability benefits to his firm's insurer, Standard Insurance Company ("Standard").

Part 6 of Standard's insurance policy issued to Kearney, the "Long Term Disability Insuring Clause," reads:

> Subject to all the terms of the GROUP POLICY, STANDARD will pay the LTD benefit described in Part 8 upon receipt of satisfactory written proof that you have become DISABLED while insured under the GROUP POLICY.

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The definition of "disability" is set forth in Part 5 of the policy and reads:

> A. DEFINITION OF DISABILITY FOR ATTORNEYS.
>
> You are only required to be DISABLED from your specialty in the practice of law.
>
> You are DISABLED from your own specialty in the practice of law if, as a result of SICKNESS, ACCIDENTAL BODILY INJURY or PREGNANCY, you are EITHER:
>
> 1. Unable to perform with reasonable continuity the material duties of your specialty in the practice of law; OR
>
> 2. Unable to earn more than 80% of your INDEX PREDISABILITY EARNINGS while working in your specialty in the practice of law.
>
> Under this definition of DISABILITY, you will be considered DISABLED while working in another occupation if you are DISABLED from your specialty in the practice of law.

On December 29, 1992, Standard approved Kearney's claim for disability benefits.

Over the next several months, Dr. Morrison continued to see Kearney. At one point, Dr. Morrison rated Kearney

as a "Class I" cardiac patient—a patient in whom ordinary activity should not cause undue fatigue, pain, or palpitation. At the same time, however, Dr. Morrison noted Kearney experienced premature ventricular contractions during his examination. In a later report, on May 11, 1993, Dr. Morrison reclassified Kearney as a "Class II" patient and wrote that he believed that he would be unable to return to his usual occupation for 6-12 months and, then, up to only 75% of his pre-surgery workload.

During the same time period, several other doctors examined Kearney and reached similar results. The first was Kearney's treating physician for 20 years, Dr. Lehman. Initially, Dr. Lehman noted that Kearney "feels he's lost 20% of his intelligence off the top." In a letter submitted to Standard on February 26, 1993, Dr. Lehman summarized the results of the cardiology examination he performed on Kearney:

> Unfortunately, the patient is manifesting evidences of cognitive impairment, which has been well reported after coronary artery bypass surgery, particularly, as in Mr. Kearney's situation, when the patient does truly have open heart surgery. . . . At the present time, I would have to consider him completely or near completely disabled, though most of these patients recover function within 6 months, and I am hopeful that we still might see some improvement in the relatively near future.

Appendix C

Dr. Lehman diagnosed Kearney with status post-coronary artery bypass and mitral valve angioplasty with "persistent fatigue and diminished intellectual capacity."

Kearney's psychiatrist, Dr. Kaufman, also submitted medical data to Standard. Dr. Kaufman reported that Kearney had a loss of memory and knowledge. Kearney, for example, failed to recollect a client with whom he had met recently. Dr. Kaufman stated that Kearney suffered from "more than average" loss of memory for this age and concluded that he would not be able to do trial work. The danger for Kearney, according to Dr. Kaufman, was that "[Kearney] doesn't know what he doesn't know."

The final doctor to examine Kearney during this period was Dr. Peter Heublein, a medical neurologist. Dr. Heublein noted in his report, which was forwarded to Standard, that Kearney stated that "he cannot return to work as a litigating attorney under the present circumstances." Dr. Heublein wrote that it was impossible to tell whether Kearney was suffering from organic brain syndrome or anxiety and depression-induced memory loss. Furthermore, Dr. Heublein stated that, because Kearney's MRI scan was "unremarkable," psychometric testing would be necessary to document Kearney's organic memory and cognitive disturbances as well as potential psychological components.

As concrete evidence of his disability, Kearney informed Standard that during two days of light work — a settlement conference and two depositions — he became "stressed out," had "PVC" palpitations, and was hospitalized briefly. Subsequent stress EKG's while

Kearney was on a treadmill did not reproduce those symptoms, indicating that they were most likely stress-induced. Once Kearney was out of the hospital and away from work, he returned to rehabilitation without further problems. In November 1993, due to his debilitated condition, Kearney closed his law office. Kearney also explained to an investigator that he had to cease teaching continuing legal education courses because he could no longer recall the civil code in a manner sufficient to permit him to answer questions. He also stated that he was able, with adequate rest, to play a few sets of doubles tennis on the weekends.

Reports submitted to Standard through the rest of 1993 continued to confirm Kearney's cognitive and stamina impairments. Dr. Lehman sent Standard a statement concluding that Kearney's "intellectual impairment precluded legal work." Dr. Lehman was unable to determine when Kearney could return to work, and added, "It's been so long, I doubt he'll recover, unfortunately." In addition, in December, 1993, Dr. Morrison informed Standard that Kearney's condition was unchanged and that he continued to be restricted by his poor memory. Dr. Morrison said that he did not know when Kearney could return to work, but recommended a follow-up appointment in six months.

In April, 1994, Standard asked another doctor of its choosing, Dr. Randall Smith, to conduct an "independent" medical examination of Kearney. Dr. Smith, a neuropsychologist, reported that he found in Kearney no evidence of cognitive deficiencies based on formal testing; that mental status exams resulted in exceptional

performance; and that there was no evidence of aphasia, paraphysis, or word-finding pauses. Dr. Smith reported that Kearney's cognitive "Shipley test" indicated average abstract reasoning skills and above average verbal skills. He characterized Kearney as possessing "superior general memory functioning and unimpaired verbal and visual memory functions" in light of these "average" scores, but noted that Kearney had done "somewhat more poorly on a measure of active attention and concentration." Finally, Dr. Smith reported that Kearney told him he had a hobby of rebuilding and driving race cars in excess of 100 miles per hour.

Despite the fact that Kearney's responses to a test administered by Dr. Smith indicated that Kearney's description of his disability symptoms was truthful, realistic, internally consistent, and suggested no psychiatric diagnosis, Dr. Smith concluded that Kearney's inability to return to work as an attorney was motivational in origin. Dr. Smith summarized his results as follows:

> [M]y evaluation of Mr. Kearney does not reveal any evidence of cognitive, verbal skill, or memory deficits which would preclude him from effectively functioning as an attorney at the present time. . . . I can certainly find no evidence of neuropsychological deficits which would prompt him to be labeled disabled. Those physicians who have drawn such conclusions have done so simply based on the patient's self-report, and not as a result of formal or systematic evaluation.

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Based on Dr. Smith's report — specifically, his medical diagnosis and his description of Kearney's hobby of driving race cars — Robert Case, Standard's claim analyst, notified Kearney by letter that his long term disability benefits would be terminated because Standard believed he was no longer unable to perform his specialty as a trial attorney.

Kearney soon wrote back to Standard urging it to reverse its decision. In support of his position, he enclosed recent reports from Dr. Irwin Weinreb, a cardiologist, and Dr. Robert Bittle, a diplomat of the American Board of Psychiatry and Neurology, that stated that Kearney probably was disabled from working as a trial attorney and that, upon further testing, this conclusion could be confirmed.

Dr. Weinreb's complete medical-cardiac evaluation revealed two abnormal EKG's and demonstrated that Kearney was prone to chronic fatigue and reduced stamina. Dr. Weinreb suspected that Kearney suffered from diminished memory owing to his heart condition and stated that, without question, he had naturally progressing coronary occlusive atherosclerotic artery vascular disease from 1988 forward. Dr. Weinreb concluded that while Kearney could do legal work outside of trial work, he should be precluded "from very heavy work and very severe emotional distress," and "certainly should avoid intense emotional stress and not be on a very tight time schedule."

Dr. Bittle's report stated that Kearney's cardiac impairment caused chronic and easily induced fatigue, and reduced stamina. Dr. Bittle also reported that although most neurocognitive deficits tend to improve with time following

cardiac surgery, he believed that Kearney fell into the minority who retain neurocognitive behavioral problems. Cognitive problems that might appear subtle, Dr. Bittle emphasized, greatly increase in the face of the stress and situations when one must remember a multitude of facts. Thus, Dr. Bittle concluded that although Dr. Smith may have correctly concluded that Kearney could return to some type of legal work, it was "highly medically probable" that his cognitive deficiency interfered significantly with his ability to function in the highly complex arena of trial work. Equally important, Dr. Bittle stated that more sophisticated testing than Dr. Smith's was needed in order to determine the extent of Kearney's potentially subtle but significant residual cognitive deficits. He explained that further neurophysiological studies could document the problems of which Kearney complained, but that Dr. Smith had not conducted such tests.

Dr. Fraback, a rheumatologist employed by Standard, was the first Standard doctor to review Kearney's supplemental reports, although he never examined Kearney himself. Because Dr. Fraback viewed Kearney's doctors' results as "suspect," he preliminarily concluded on the basis of the medical reports that Kearney would be able to practice as a trial attorney. (Dr. Fraback provided no explanation regarding his knowledge of the duties of a trial attorney.) At the same time, however, he strongly advised Standard to procure Dr. Weinreb's EKG's and other medical data for further study. If the EKG's were accurate, Dr. Fraback explained, then Kearney's heart condition would indeed constitute a significant impairment.

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In an addendum to his earlier report, Dr. Smith also reviewed the reports of Dr. Weinreb and Dr. Bittle. Without performing any additional physical examination or analysis, Dr. Smith said that he found no neuropsychological reason Kearney could not return to work as an attorney, "even in a trial setting." At the same time, however, Dr. Smith conceded that "whether there are cardiovascular preclusions to returning to the work of a trial attorney is outside of the realm of my expertise to determine." Finally, he admitted to not performing the tests that Kearney's doctors recommended, but reminded Standard that he had not been asked to perform such tests and claimed that, given Kearney's symptoms, they were unnecessary in any event.

Standard never sought to obtain the medical data that Dr. Fraback recommended it review. Instead, on January 27, 1995, its Quality Assurance Unit reviewed Kearney's claim and decided not to reverse its decision to terminate his long term disability benefits. Standard wrote:

> The occupation of a trial attorney is sedentary and falls well within the physical restrictions outlined by Dr. Weinreb. Much of the work involves conducting research and does not require being in court or on a very tight time schedule.
>
> . . . We do not dispute that Mr. Kearney cannot continue to work 75 hours per week managing the business end of his law firm, trying his own cases, and running his leasing company, in addition to pursuing his hobby of racing cars.

> . . . [However, t]he issue upon which we must focus is whether or not he has the physical and mental capabilities to perform, with reasonable continuity, the material duties of a trial attorney, as it is performed in the general economy. Based on our review, we do not find satisfactory evidence to support your client's claim that he is so impaired mentally and physically that he is unable to practice as a trial attorney.

On March 7, 1995, having exhausted his administrative remedies, Kearney filed the instant suit, alleging that Standard had terminated his benefits in violation of ERISA, 29 U.S.C. § 1132(a)(1)(B) (1994).

After the parties filed cross motions for summary judgment, the district court granted summary judgment in favor of Standard. First, the court held that Kearney was entitled to a de novo review of the record, but limited its scope of review to the evidence before Standard when it denied benefits for the last time. Hence, the court prevented Kearney from offering expert evidence describing the material duties of a person engaged in his specialty, as well as additional medical evidence elaborating on his physical condition and on the relationship between cardiac impairments and performance of a trial lawyer's duties. In a second order, the court ruled that Kearney's condition failed, as a matter of law, to constitute a disability under the terms of the policy. The court concluded that:

> The fact that plaintiff should, like most of us, avoid severe emotional stress or very hard work

> does not warrant the conclusion that he cannot practice as a trial attorney. . . .
>
> . . . .
>
> [T]here is no question that plaintiff's physical and mental stamina has been weakened by his heart condition. Unfortunately, the LTD policy does not insure that he would forever remain at his former state of health and stamina. Without sufficient evidence that the condition left him so disabled that he cannot perform the functions of a trial attorney, plaintiff's claim fails.

In addition, the court held that the second definition of "disabled" in the long term disability policy — the inability to earn 80% of predisability earning while working in the attorney's specialty — did not apply because Kearney was not working at the time Standard decided to terminate his claim.[2]

Kearney then filed a motion under Rule 59(e) to vacate the judgment or, in the alternative, for entry of a new and different judgment. The district court denied his motion without oral argument and ordered him to pay attorneys' fees to Standard to compensate it for the cost of litigating his motion.

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2. Because we conclude, infra at Part III, that the district court erred in granting summary judgment based on the policy's first definition of disabled, we need not consider whether its dubious interpretation of the second definition is correct.

Appendix C

Kearney now appeals both of the district court's decisions, arguing that the district court should have granted summary judgment in his favor (or, at least, should have denied Standard's motion for summary judgment) and that it erred in assessing attorneys' fees against him on his Rule 59(e) motion.

DISCUSSION

In Parts I and II, we determine the proper standard and scope of judicial review of Standard's decision to deny Kearney disability benefits. Then, in Part III, we review the district court's decision upholding the denial of benefits. Finally, in Part IV, we address the award of attorneys' fees.

I. Standard of Review

Kearney's policy read, in relevant part, that Standard would pay long term disability benefits "upon receipt of satisfactory written proof that you have become DISABLED while insured under the GROUP POLICY." Because the district court found that this clause did not "unambiguously vest[ ] the administrator with discretionary power" to determine eligibility for long term disability benefits, it reviewed the case de novo. Standard contends that, particularly due to our intervening holding in Snow v. Standard Ins. Co., 87 F.3d 327, 330 (9th Cir.1996), the policy does vest discretionary authority in the administrator; thus, it asserts, the district court and this court must review the administrator's decision for an abuse of discretion. Standard is mistaken. We have never held that so imprecise and ambiguous a provision as contained in Kearney's policy

vests discretion in the administrator, and we decline to do so now.

In an action to recover benefits under an ERISA plan, the district court must review the administrator's denial of benefits de novo "unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the plan." Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115, 109 S.Ct. 948, 956-57, 103 L.Ed.2d 80 (1989). When the administrator retains such discretionary authority, the district court ordinarily will review the administrator's determinations for an abuse of discretion. See Snow, 87 F.3d at 330; Winters v. Costco Wholesale Corp., 49 F.3d 550, 552 (9th Cir.), cert. denied, 516 U.S. 908, 116 S.Ct. 276, 133 L.Ed.2d 197 (1995). If the plan's funding source and its administrator are the same entity, however, and if facts suggest that the entity acted out of self-interest, the denial of benefits will be subject to de novo review. See Lang v. Long-Term Disability Plan, 125 F.3d 794 (9th Cir.1997); Atwood v. Newmont Gold Co., 45 F.3d 1317, 1322-23 (9th Cir.1995). Here, de novo review is warranted for two reasons, either one of which would be sufficient: (1) Standard did not retain discretionary authority and (2) it has not rebutted the evidence indicating that its decision was affected by a conflict of interest.

First, we have previously explained that a plan gives the fiduciary the authority to determine eligibility only if the plan includes at least "one important discretionary element, and the power to apply that element is unambiguously retained by its administrator." Bogue v.

Ampex Corp., 976 F.2d 1319, 1325 (9th Cir.1992), cert. denied, 507 U.S. 1031, 113 S.Ct. 1847, 123 L.Ed.2d 471 (1993) (emphasis added). If the administrator does not retain the "power to apply" a discretionary element, it must apply the plan in a purely objective manner, and, more important, courts do not defer to its judgment. In Snow, this court applied the principle explained in Bogue, holding that a plan providing that "there will be no benefit unless Standard is presented with what it considers to be satisfactory written proof of the claimed loss" unambiguously vested discretion in the administrator. 87 F.3d at 330 (emphasis added).[3]

In this case, as in Snow, the plan contains a requirement of satisfactory written proof. Contrary to Standard's assertion, however, our holding in Snow does not render erroneous the district court's determination regarding the applicable standard of review. As the district court correctly recognized, the language of the plan before us vests Standard with authority to administer the plan and to condition Standard's obligation to pay on an insured's compliance with certain specified requirements, including the offering

3. Despite the fact that Standard issued the plans in both Snow and the present case, it is apparent that at least some of the language of the two plans differs. The plan in this case applies only to attorneys, while the plaintiff in Snow was not an attorney. Furthermore, for what it may be worth, that we have reservations as to the effect we would give any representation by Standard that the language of the two plans was identical. Snow does not quote the plan's language, and we doubt that we are free to look behind the text of the opinion in an effort to ascertain facts that the court failed to set forth or determine. What matters here is that we described the policy in Snow as requiring proof that Standard considers to be satisfactory.

of "satisfactory written proof" of a disability. Yet the plan here, as opposed to the one described in Snow, does not state that Standard retains the authority to determine what it considers to be "satisfactory written proof." At best, from Standard's viewpoint the plan that covers Kearney is ambiguous as to whether Standard is granted the discretion to apply its subjective judgment or whether the question of what proof is satisfactory must be determined objectively under applicable legal and medical principles. The distinction is hardly trivial. If, as in Snow, Standard retains the authority to deny benefits when it believes in good faith that insufficient proof is offered, it also retains the discretion to give substance to its own standard. See 87 F.3d at 330; see also Donato v. Metropolitan Life Ins. Co., 19 F.3d 375, 379-80 (7th Cir.1994) (plan used phrase "all proof must be satisfactory to us"); Miller v. Metropolitan Life Ins. Co., 925 F.2d 979, 983 (6th Cir.1991) (plan used phrase "on the basis of medical evidence satisfactory to the Company"). If the standard of proof is an objective one, however, Standard may deny benefits only to the extent that courts independently would conclude that the evidence fails to constitute satisfactory written proof. Thus, the different standards of review.

The plan's uncertainty on this point is fatal to Standard's assertion of discretionary authority and requires us to adopt a purely objective approach to claimants' eligibility for benefits. We explained in Bogue that "[l]anguage that establishes only an entity's right to administer or manage a plan does not confer discretion." 976 F.2d at 1325; see also Bruch, 489 U.S. at 111, 109 S.Ct. at 954-55. More important, we added:

> We do not want to encourage an employer to insulate himself from effective appellate review through the abuse of vague phrases that fail to make clear to the employees that the employer will have the final determination of benefit decisions. Employees who lose promised benefits should not lose the additional benefit of judicial review because their employer reserved discretionary power to itself without making that reservation clear.

Bogue, 976 F.2d at 1325. Thus, drafters of plans, if they wish the courts' review to be limited, must leave no doubt in the language of the plan that an administrator has the authority to construe the terms of the plan and to exercise its discretion when making eligibility decisions. Otherwise, ambiguities will be construed against the drafter and eligibility determinations will be evaluated under an objective standard.

The plan in Snow allowed Standard to deny benefits when not faced "with what it considers to be satisfactory written proof"; the plan in this case, however, speaks only in general terms of the claimant's obligation to submit "satisfactory written proof." The district court was, therefore, right to conclude that the plan fails "unambiguously" to provide Standard with the discretion to make eligibility determinations.[4] And nothing in Snow

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4. This conclusion is bolstered by this court's rule that ambiguities in ERISA insurance contracts are to be construed against the drafter. McClure v. Life Ins. Co., 84 F.3d 1129 (9th

(Cont'd)

alters the correctness of that decision. Indeed, faced recently with a plan with nearly identical language as the plan in this case,[5] the Sixth Circuit, at least initially, reached the same conclusion we do. It explained:

> Simply because [the administrator] has the ability to require written proof before continuing disability benefits does not mean that [the administrator] has the discretionary authority to decide whether that proof is sufficient within the meaning of the Plan. Second, simply because [the administrator] may require "satisfactory proof" does not give the insurance company discretionary authority. . . . The quoted plan provision does not specify to whom the proof should be satisfactory. [The plaintiff] probably is correct in arguing that this language creates an objective standard — proof "satisfactory" to a reasonable person. But all we need decide at this point is that the language does not clearly give [the administrator] discretion, which is what the language of an ERISA plan must do under Bruch to trigger abuse of discretion review.

(Cont'd)
Cir.1996), citing Kunin v. Benefit Trust Life Ins. Co., 910 F.2d 534, 539-540 (9th Cir.) (as amended), cert. denied, 498 U.S. 1013, 111 S.Ct. 581, 112 L.Ed.2d 587 (1990).

5. The plan stated that: "Subsequent written proof of the continuance of such disability must be furnished to [the company] at such intervals as [the company] may reasonably require. . . . [The company] shall have the right to require as part of the proof of claim satisfactory evidence." 96 F.3d at 825.

Perez v. Aetna Life Ins. Co., 96 F.3d 813, 826 (6th Cir.1996);[6] see also Williamson v. Unum Life Ins. Co., 943 F.Supp. 1226, 1228-29 (C.D.Cal.1996) (post-Snow case holding same and distinguishing plans that explicitly vest authority in administrator). We agree with this reasoning. The plan's lack of explicit delegation of discretionary authority to Standard requires that (1) Standard apply an objective standard when determining questions such as what constitutes satisfactory written proof and (2) Standard's determinations be reviewed on a de novo basis.

Second, de novo review also is required in this case because the record suggests that Standard was influenced by the practical conflict of interest that exists in this case, in which it is both the insurer and the administrator. See Lang, 125 F.3d at 798. If evidence indicates that a plan administrator's "self interest caused a breach of the administrator's fiduciary obligations to the beneficiary," we employ a searching inquiry in which "the plan bears the burden of producing evidence to show that the conflict of interest did not affect the decision to deny benefits." Atwood, 45 F.3d at 1323. While two of our recent opinions in which no conflict was found might seem at first glance to suggest that we review a conflicted administrator's decision only "more stringently," but not fully de novo, a closer examination of our cases reveals that we do in fact review such decisions de novo if an actual conflict exists.

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6. The Sixth Circuit has since vacated this decision and reheard the case en banc to reconsider this issue and others. 106 F.3d 146 (6th Cir.1997). The en banc court has not yet announced its decision. However, our decision is in no way dependent on the en banc court's adopting the panel decision with which we agree.

Compare Estate of Shockley v. Alyeska Pipeline Serv. Co., 130 F.3d 403, 405 (9th Cir.1997) (stating that when evidence exists "tending to show that the fiduciary's self-interest" resulted in a conflict of interest "we have imposed more searching scrutiny "— but finding no conflict to exist, so not further describing that scrutiny) (internal quotation marks omitted and emphasis added) and Snow, 87 F.3d at 331 (stating that in conflict cases "the standard of review would not exactly change, but scrutiny of [the administrator's] decision would become more searching" — but finding no conflict to exist, so not further describing that type of scrutiny) (emphasis added) with Lang, 125 F.3d at 798 (holding that when there is an actual conflict of interest "our review becomes de novo, without deference to the administrator's tainted exercise of discretion" and applying de novo review) (internal quotation marks omitted) and Atwood, 45 F.3d at 1322-23 (holding that when a conflict of interest actually exists "we will review the decision de novo, without deference to the administrator's tainted exercise of discretion").

As Judge Sneed's concurrence accurately states, our opinion in Atwood — the first we issued on the subject, and upon which both Estate of Shockley and Snow (as well as Lang) draw — harmonizes these cases by explaining that we actually "review apparently conflicted [administrators] in two steps." Atwood, 45 F.3d at 1323. We first, following well established principles of trust law and the Supreme Court's opinion in Bruch, apply a " 'less deferential' standard . . . to apparently conflicted fiduciaries" to determine whether an actual conflict exists by shifting the burden to the administrator to demonstrate that either

(1) no conflict actually exists or (2) that the conflict did not "affect the decision to deny benefits." Id. (emphasis added). "If the plan cannot carry that burden," then "we will review the [administrator's] decision de novo without deference to the administrator's tainted discretion." Id. In other words, as Atwood further explains, "[u]nder this standard, if a conflicted fiduciary's interpretation which advances the fiduciary's interest at the expense of the beneficiary's is 'wrong' under de novo review but still 'apparently reasonable,' the fiduciary has committed an abuse of discretion unless the plan can show that the interpretation was not made to serve its conflicting interest." Id. at 1322 (quoting Brown v. Blue Cross & Blue Shield, 898 F.2d 1556, 1566-67 (11th Cir.1990)). Both Estate of Shockley and Snow found occasion only to apply the first step of the Atwood analysis, so they never reached the step of applying de novo review to the actual decision. If, in those cases, the administrator had not carried its burden of dispelling the evidence of a potential conflict, de novo review would have applied, just as in Lang.

Here, after Kearney's doctor, Dr. Weinreb, diagnosed Kearney as disabled, Standard's doctor, Dr. Fraback, strongly suggested that Standard obtain Dr. Weinreb's test results, which had indicated that Kearney's ability to practice his specialty was significantly impaired by his heart condition. Yet Standard failed to obtain or to consider the results of Dr. Weinreb's tests and simply proceeded to deny Kearney's claim. Standard's lack of interest in reviewing relevant medical data is sufficient to suggest that it acted out of self- interest. Finally, Standard has failed to show that its failure to obtain the additional information could

not have affected its eligibility decision. See Lang, 125 F.3d at 798.

II. The Scope of Review

Kearney argues that the district court erred in limiting its scope of review to the evidence that was before Standard when Standard made its decision to terminate his benefits. He contends that, because of the complexity of the issues involved, he should have been able to present additional evidence beyond that in the administrative record regarding the material duties of a trial attorney and whether his heart condition prevents him from performing some of those duties. We agree and hold that the district court abused its discretion in refusing to admit such evidence.

The purpose of de novo review in ERISA cases "is to provide greater assurance that employees will get the benefits to which they are entitled under the written terms of the plan documents." Orozco v. United Air Lines, Inc., 887 F.2d 949, 953 (9th Cir.1989). In general, however, courts conducting de novo review of ERISA benefits claims should limit the evidentiary record to that which was before the plan administrator at the time of its decision. Mongeluzo v. Baxter Travenol Long Term Disability Benefit Plan, 46 F.3d 938, 943 (9th Cir.1995). Nonetheless, "new evidence may be considered under certain circumstances to enable the full exercise of informed independent judgment" when applying de novo review. Id.

In Mongeluzo, we joined a number of other circuits in following the Fourth Circuit's approach to this issue,

holding that the district court was required to admit evidence beyond what was presented to the administrator "when circumstances clearly establish that additional evidence is necessary to conduct an adequate de novo review of the benefit decision." Id. at 944 (quoting Quesinberry v. Life Ins. Co., 987 F.2d 1017, 1025, (4th Cir.1993) (en banc)).[7] In reversing the district court's refusal to admit the additional evidence offered by the plaintiff, we emphasized, however, that district courts should not admit additional evidence "merely because someone at a later time comes up with new evidence that was not presented to the plan administrator." Id. Some of the circumstances that courts should consider in determining whether to allow additional evidence are set forth in Quesinberry. They include:

> claims that require consideration of complex medical questions or issues regarding the credibility of medical experts; the availability of very limited administrative review processes with little or no evidentiary record; the necessity of evidence regarding interpretation of the terms of the plan rather than specific historical facts; instances where the payor and the administrator are the same entity and the court is concerned about impartiality; . . . and circumstances in which there is additional evidence that the claimant could not have presented in the administrative process.

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7. See also Casey v. Uddeholm Corp., 32 F.3d 1094, 1098-99 & n. 4 (7th Cir.1994); Luby v. Teamsters Health, Welfare and Pension Trust Funds, 944 F.2d 1176, 1184-85 (3rd Cir.1991); Moon v. American Home Assurance Co., 888 F.2d 86, 89 (11th Cir.1989).

Quesinberry, 987 F.2d at 1026-1027. This list is, of course, not exhaustive. Id. at 1027. Because Quesinberry involved (1) complex, medical testimony, (2) the interpretation of a key provision in the plan, and (3) a circumstance in which the payor was also the administrator, the Fourth Circuit held that the district court's decision to allow additional evidence was proper. Id. at 1027.

The same three factors present in Quesinberry are present in this case, and one raises especially strong concerns — namely, that Standard, acting under a conflict of interest, neglected to obtain additional medical evidence that its own doctor said could establish Kearney's disability. First, the medical issue regarding the extent of Kearney's cognitive deficiency, and its connection to his heart condition, is decidedly complex, as is the question of the extent to which his cardiac condition limits his ability to undergo stress and perform hard work. The doctors' reports on these issues do not always meet head-on, and credibility issues exist. Yet the district court held that it was "well able to review the issues presented without need for additional evidence." We disagree. "[W]here the record contains numerous and possibly conflicting medical terms and diagnoses, excluding new evidence would force this court to become its own medical expert." Peters v. Life Ins. Co. of N. Am., 816 F.Supp. 615, 618-19 (N.D.Cal.1993); see also Quesinberry, 987 F.2d at 1027 (stating that "if the court is faced with a complex medical issue on which testimony from experts is necessary for an adequate understanding of the issue and the administrative procedures do not have a mechanism for taking such testimony, allowing such testimony would be appropriate"); Masella

v. Blue Cross & Blue Shield, 936 F.2d 98, 104-05 (2d Cir.1991) (same). Here, this factor weighed heavily against foreclosing Kearney's ability to submit additional medical evidence — recommended by an array of doctors—that would help develop an adequate understanding both of the extent of his cognitive deficits and the relationship to his heart condition, and the extent of his diminished physical capacity to work long hours and incur serious stress. The district court, instead, unnecessarily risked becoming, in effect, "its own medical expert." Peters, 816 F.Supp. at 619.

Second, Kearney's claim turned on the interpretation of a key provision of the plan, the definition of the "material duties" of a trial attorney. The plan administrator's conclusion that trial attorneys' duties were "sedentary," and the lack of information in the administrative record describing the typical duties of trial attorneys, should have alerted the district court to the possibility that the administrator was misinformed or uniformed as to the material duties of a trial attorney. The term "sedentary," as the Social Security Administration defines it, classifies work according to the required physical exertion only and in no way accounts for the required mental stamina, stress-related endurance, or memory skills. See 20 C.F.R. § 404.1567(a) (1997). Similarly, the dictionary definition of the term "sedentary" refers solely to the amount of physical exertion involved and does not consider other requirements. See 2 The New Shorter Oxford English Dictionary 2755 def'n 2 (4th ed.1993) ("characterized by or requiring much sitting and little physical exercise"). All this, of course, is wholly aside from the odd assumption that trial counsel are primarily chairbound. The mental exertion required and the

degree of stress that is inherent in the performance of one's duties obviously makes trial advocacy considerably more demanding for legitimate cardiac patients than ordinary sedentary work. The administrator's questionable conception of the nature of the claimant's work might, in itself, make it "necessary for the case to be reevaluated" under the proper definition. See Mongeluzo, 46 F.3d at 944 (holding that, where the original hearing was conducted under a misconception of the meaning of the plan's provisions, case must be remanded to consider additional evidence); see also Saffle v. Sierra Pac. Power Co. Bargaining Unit Long Term Disability Income Plan, 85 F.3d 455, 461 (9th Cir.1996) (same); Quesinberry, 987 F.2d at 1027 (same). Additional evidence regarding the nature of trial work would, at a minimum, have aided the district court in conducting its de novo review of whether Dr. Weinreb's warning to avoid stress and hard work rendered Kearney disabled. See McClure v. Life Ins. Co. of N. Am., 84 F.3d 1129, 1134 (9th Cir.1996) (per curiam) (holding that pertinent inquiry is whether plaintiff is prevented from performing a single material duty). It therefore should have been admitted.

Third, Standard was both the plan's payor and its administrator, which should have caused the district court to be alert to questions regarding impartiality. Quesinberry, 987 F.2d at 1026-1027; see also Snow, 87 F.3d at 331 (noting that "if the plan administrator is operating under a conflict of interest, 'that conflict must be weighed as a factor in determining whether there is an abuse of discretion' ") (quoting Bruch, 489 U.S. at 115, 109 S.Ct. at 956-57). Standard stood to lose some $1,172,000, excluding cost of

living adjustments, if it continued to pay Kearney's claim. Moreover, the record suggests that this conflict may have affected its review of Kearney's claim. See Atwood, 45 F.3d at 1322-1323 (if plaintiff produces evidence of conflict, court should review administrator's decisions "very skeptically"). Standard ignored various doctors' recommendations, including a recommendation by its own doctor, that it obtain existing and additional medical data — including Kearney's electrocardiogram and stress EKG performed by Dr. Weinreb (both of which were abnormal) — to help develop the particularities of Kearney's condition. In fact, Standard's doctor, Dr. Fraback, although skeptical of Dr. Weinreb's report, indicated to Standard that Kearney probably would in fact be disabled if Dr. Weinreb's EKG confirmed his diagnosis. It is quite possible that the administrative record was in conflict in large part because Standard failed to obtain this information. Because the "procurement of further evidence" regarding Kearney's heart condition might have altered the administrator's decision, the district court, at the very least, should have allowed additional evidence regarding the efficacy of the additional tests. See Snow, 87 F.3d at 333 (emphasizing the importance of obtaining exams by specialists when decision is reviewed de novo). This factor, therefore, also strongly counseled in favor of admitting additional evidence. See Quesinberry, 987 F.2d at 1027.

Given the cumulative weight of these compelling reasons to allow evidence from outside the administrative record, we hold that the district court abused its discretion in refusing to permit Kearney to adduce additional evidence before it. The district court should have allowed Kearney

to present (1) medical evidence aimed at explaining and resolving the somewhat conflicting medical diagnoses and (2) evidence describing the material duties of trial attorneys.

III. The Merits

Although the district court's failure to admit evidence beyond that contained in the administrative record in itself requires us to remand this case for further proceedings, see Mongeluzo, 46 F.3d at 938, we are also compelled to reverse the district court's grant of summary judgment in favor of Standard because the record, even as it now stands, contains unresolved issues of material fact. Thus, even if Kearney had not sought to present additional evidence, or if the additional evidence would not have further advanced his claim, the district court's summary judgment decision would be in error.

The district court held, despite the nearly unanimous agreement to the contrary among the physicians who treated or examined Kearney, that he was able to perform all of his duties as a trial attorney. Specifically, the court ruled that "there is no question that plaintiff's physical and mental stamina has been weakened by his heart condition", but that "the fact that plaintiff should, like most of us, avoid severe emotional stress or very hard work does not warrant the conclusion that he cannot practice as a trial attorney."

We must determine whether Standard has demonstrated that no issues of material fact remain as to whether Kearney was unable to perform at least one of the material duties of a trial attorney when Standard terminated his disability

benefits. See Bagdadi v. Nazar, 84 F.3d 1194, 1197 (9th Cir.1996) (movant retains burden of persuasion); McClure, 84 F.3d at 1134 (holding that pertinent inquiry is whether plaintiff is prevented from performing a single material duty). We conclude that the record reflects genuine issues of material fact regarding (1) the extent of Kearney's physical and cognitive impairments and (2) the question whether, even if those impairments preclude him only from undergoing severe stress and engaging in very hard work, Kearney was able to perform all of the material duties of a trial attorney.

First, it is somewhat difficult to understand how the district court could conclude that Kearney was not disabled as a matter of law when every one of the treating and examining physicians, save Dr. Smith, either concluded that he was disabled or recommended further testing on the basis that he probably was disabled. Cf. Pitzer v. Sullivan, 908 F.2d 502, 506 n. 4 (9th Cir.1990) (noting that nonexamining physician's opinion should be given less weight than examining physician). Dr. Weinreb, for example, reported as late as October, 1994 (four months after Dr. Smith's exam) that Kearney "could do legal work outside of trial work, wherein he can work within his disability described above, both physically and emotionally." This statement strongly suggested that "trial work" was still out of the question. Dr. Bittle also reported that Kearney's cognitive impairments probably precluded trial work and that further tests could confirm that prognosis. And all the while, Kearney's treating physicians, Dr. Morrison and Dr. Lehman, flatly diagnosed Kearney as disabled. Furthermore, it seems quite debateable that Kearney's ability to play some

doubles tennis and his occasional practice of driving a race car— both of which were heavily relied on by Standard and the district court in denying Kearney's claim—are in any way inconsistent with an inability to perform all of the material duties of a trial attorney without seriously jeopardizing one's health.[8] To be sure, Dr. Smith concluded that Kearney's relevant impairments were "motivational in nature" (itself a curious conclusion regarding a person with a classic Type A personality), but the point is that, in the face of contradictory evidence, the district court should have refrained from resolving the issue of Kearney's medical condition at the summary judgment stage. See, e.g., Abdul-Jabbar v. General Motors Corp., 85 F.3d 407, 410 (9th Cir.1996) (courts at summary judgment stage must not weigh the evidence or determine the truth of the matter).

Second, an issue of material fact remains regarding the "material" duties of trial attorneys. A material duty is any duty that a person must perform in order to execute the functions of an occupation. See Rowan v. Unum Life Ins. Co. of Am., 119 F.3d 433, 434, 436-37 (6th Cir.1997). Kearney submitted evidence from a Department of Labor handbook stating that trial attorneys "need an exceptional ability to speak quickly and speak with ease and authority and must be thoroughly familiar with courtroom rules and

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8. Whether it is wise for a person with a heart condition, or indeed anyone, to drive race cars occasionally, or frequently, is a question beyond the scope of this opinion. It is sufficient to note for our purposes that if people who are sick or disabled engage in unhealthy or unwise activities it does not render them physically unimpaired. People who continue to smoke after contracting lung cancer may not for that reason be classified as cancer-free.

strategy. . . . [ ] Lawyers often work long hours, and about half regularly work 50 hours or more per week. They are under particularly heavy pressure, for example, when a case is being tried." Standard, on the other hand, claimed that the "occupation of a trial attorney is classified as sedentary. . . . Much of the work involves conducting research and does not require being in court or on a very tight time schedule." It is unclear whether the district court agreed with this seemingly odd conclusion of Standard's regarding the life of a trial lawyer or whether it substituted a related definition of its own. Regardless of whether a finding along the lines suggested by Standard could ever stand up to scrutiny, it was erroneous for the court to reject the evidence offered by Kearney with the only conflicting evidence in the record being Standard's. If the court had accepted as true Kearney's evidence that performing the job of a trial attorney involves long hours, hard work and considerable stress,[9] it probably would have had to find that Kearney was legally disabled in light of Dr. Weinreb's explicit admonitions to avoid such working conditions. See McClure, 84 F.3d at 1134 (holding that pertinent inquiry is whether plaintiff is prevented from enduring working condition necessary to perform even a single material duty of job). For present purposes, however, we need only conclude that a genuine issue of material fact remains to be resolved.

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9. Kearney also correctly reminded the court that one of his material duties is his ethical obligation to his clients to withdraw from representation when he cannot devote sufficient time, energy or quality service to their cause. See Cal. R. Prof. Conduct 3-110, 3-700; Cal. Bus. & Prof.Code § 6190. The court made no findings as to whether Kearney could properly carry on his specialty in light of this obligation.

Appendix C

IV. Attorneys Fees and Costs

Shortly after the district court ordered summary judgment in favor of Standard, Kearney moved under Rule 59(e) to vacate the judgment, pointing out the district court's errors and arguing that an intervening Ninth Circuit case, McClure, demonstrated that the district court's order of summary judgment was wrong. The district court denied the motion, and at Standard's request, ordered Kearney to pay attorneys' fees to compensate it for its legal fees in litigating what the district court called a "groundless" motion. Kearney appeals the fee award.[10] We reverse.

"We review the district court's decision to award fees against an ERISA claimant for abuse of discretion." Estate of Shockley v. Alyeska Pipeline Serv. Co., 130 F.3d 403, 407 (9th Cir.1997). We generally consider the following factors in awarding fees under ERISA:

> (1) the degree of the opposing party's culpability or bad faith; (2) the ability of the opposing party to satisfy an award of fees; (3) whether an award of fees against the opposing party would deter others from acting under similar circumstances; (4) whether the party requesting fees sought to benefit all participants and beneficiaries of an

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10. Kearney also seeks attorneys' fees under 29 U.S.C. § 1132(g)(1) (1994), which permits plan participants who prevail in ERISA actions to recover fees. Since we remand this case for further proceedings, neither party has "prevailed" in this matter. We, therefore, dismiss this claim as not yet ripe. See McClure, 84 F.3d at 1136.

ERISA plan or to resolve a significant legal question regarding ERISA; and (5) the relative merits of the parties' positions.

Credit Managers Ass'n v. Kennesaw Life & Acc. Ins., 25 F.3d 743, 748-49 (9th Cir.1994); Hummell v. S.E. Rykoff & Co., 634 F.2d 446, 453 (9th Cir.1980). As the Seventh Circuit has explained, even though these factors do not differentiate between plaintiffs and defendants, they "will seldom dictate an assessment of attorneys' fees against ERISA plaintiffs." Marquardt v. North Am. Car Corp., 652 F.2d 715, 719 (7th Cir.1981). We have long recognized the same. See, e.g., Carpenters S. Cal. Admin. Corp. v. Russell, 726 F.2d 1410, 1416 (9th Cir.1984) (noting that "the Hummell factors very frequently suggest that attorney's fees should not be charged against ERISA plaintiffs").[11]

The fifth factor alone proves dispositive here. Kearney's motion pointed the district court to errors it had made regarding the merits of his case, which are highlighted by McClure 's emphasis that an ERISA-disability plaintiff need

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11. We stated in Estate of Shockley that in the context of ERISA attorneys fees awards we do not "favor one side or the other in ERISA fee cases"; "the playing field is level." 130 F.3d at 408. Of course the Hummel factors apply equally to both sides. We do not read Estate of Shockley's statement, however, to contradict or alter what we have repeatedly said: the Hummel factors " ' "very frequently suggest that attorney's fees should not be charged against ERISA plaintiffs." ' " Credit Manager's Ass'n v. Kennesaw Life & Accident Ins. Co., 25 F.3d 743, 748 (9th Cir.1994) (quoting Tingey v. Pixley-Richards West, Inc., 958 F.2d 908, 909 (9th Cir.1992) (quoting in turn Russell, 726 F.2d at 1416)).

demonstrate only that he is unable to perform a single material duty of his specialty. The district court, therefore, was incorrect in concluding that his motion was "groundless." Indeed, because Kearney was correct in his assignment of error, he more than adequately raised a "colorable claim of clear error," Thomassen v. United States, 835 F.2d 727, 731 (9th Cir.1987), making an award of fees and costs inappropriate in any context, let alone under ERISA. See id.

CONCLUSION

We reverse the district court's grant of summary judgment in favor of Standard and remand the case with instructions to allow Kearney to present additional evidence to support his claim. We also reverse the district court's award of attorneys fees to Standard.

REVERSED AND REMANDED.

Appendix C

SNEED, Circuit Judge, with whom Judges FLETCHER and REINHARDT join, concurring:

Our decision in Atwood v. Newmont Gold Co., 45 F.3d 1317 (9th Cir.1995), is the basic authority on which this case rests. I do not read our opinion to differ on this point. In contrast we apply the Atwood's "less deferential" standard which requires a two-step review process. The first of these steps requires the determination

> whether the affected beneficiary has provided material, probative evidence, beyond the mere fact of the apparent conflict, tending to show that the fiduciary's self-interest caused a breach of the administrator's fiduciary obligations to the beneficiary. If not, we apply our traditional abuse of discretion review. On the other hand, if the beneficiary has made the required showing, the principles of trust law require us to act very skeptically in deferring to the discretion of an administrator who appears to have committed a breach of fiduciary duty.

Id. at 1323. We hold that the beneficiary in this case made the showing required by the first step.

Under these circumstances, the Atwood decision requires that "the plan bears the burden of producing evidence to show that the conflict of interest did not affect the decision to deny benefits." Id. In this case Standard Insurance Company did not meet this burden. Under these circumstances, we reviewed Standard's decision de novo.

Appendix C

While Standard Insurance Company contends that it met its burden, we find otherwise.

APPENDIX D — MEMORANDUM AND ORDER OF THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF CALIFORNIA DATED JUNE 4, 1996 AND FILED JUNE 5, 1996

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF CALIFORNIA

NO. CIV. S-95-415 WBS/JFM

REX T. KEARNEY, JR.,

Plaintiff,

v.

STANDARD INSURANCE COMPANY, a corporation,

Defendant.

MEMORANDUM AND ORDER

Plaintiff's complaint alleges claims for relief under the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. section 1132(a)(1)(B). Plaintiff alleges that defendant Standard Insurance Company ("Standard") improperly terminated benefits due him under a long term disability insurance policy ("LTD Policy") established under ERISA. Presently before the court is Standard's motion for summary judgment. For the reasons that follow, the motion is granted.

Appendix D

BACKGROUND

On November 3, 1992, plaintiff underwent a 5-vessel by-pass surgery. At the time of the surgery, plaintiff was employed full time as the "president" or managing partner in the law firm of Ingoglia, Marskey & Kearney ("IMK") and was covered by IMK's LTD Policy. The LTD Policy provides long term disability benefits for covered employees who become totally disabled. With respect to an employee who is an attorney, the LTD Policy defines "disability" as follows:

> You are only required to be DISABLED from your speciality in the practice of law.
>
> You are DISABLED from your own specialty in the practice of law if, as a result of SICKNESS, ACCIDENTAL BODILY INJURY or PREGNANCY, you are EITHER:
>
> 1. Unable to perform with reasonable continuity the material duties of your specialty in the practice of law; or
>
> 2. Unable to earn more than 80% of your INDEXED PREDISABILITY EARNINGS while working in your specialty in the practice of law.[1]

Ferney Decl. Ex. 1, p. 707.

1. The second definition is not applicable because it only applies to insureds who are actually working, but are unable to earn the amount specified. Plaintiff is retired.

Appendix D

Pursuant to the terms of the LTD Policy, plaintiff was considered disabled for almost two years (December 29, 1992-September 6, 1994), and received the maximum LTD benefit of $8,000 per month until November 2, 1994. On September 6, 1994, Standard notified plaintiff that his disability benefits were terminated based primarily upon his medical records and reports provided by plaintiff's treating physician, Dr. Lehman, Dr. Morrison, a cardiologist, and Dr. Smith, a psychologist. Plaintiff then requested that Standard conduct an independent review of its decision to close the claim, and Standard agreed.

Thereafter, Standard provided plaintiff's counsel with records relevant to its decision to terminate. Plaintiff, in support of his claim of disability, then provided Standard with medical reports of Dr. Bittle, a medical doctor specializing in neuropsychiatry, and Dr. Weinreb, a cardiologist. After reviewing plaintiff's file, Standard's Quality Assurance Unit advised plaintiff on January 27, 1995 that Standard would not reverse its decision. Plaintiff then filed this suit.[2]

SUMMARY JUDGMENT STANDARD

Summary judgment is appropriate if the record, read in the light most favorable to the non-moving party,

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2. Because plaintiff may pursue claims for equitable relief against Standard to enforce the terms of the policy, Standard's contention that it is not a proper party defendant to this action is without merit. *See Spain v. Aetna*, 13 F.3d 310, 312 (9th Cir. 1992); *Gibson v. Prudential Ins. Co. of America*, 915 F.2d 414, 417 (9th Cir. 1990).

demonstrates no genuine issue of material fact. *Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986). Material facts are those necessary to the proof or defense of a claim, and are determined by reference to the substantive law. *See Anderson v. Liberty Lobby*, 477 U.S. 242, 248 (1986). At the summary judgment stage the question before the court is whether there are genuine issues for trial. The court does not weigh evidence or assess credibility. *Id.*

DISCUSSION

A. Standard and Scope of Review

Standard's decision to terminate plaintiff's claim because it found that plaintiff was no longer disabled as defined by the LTD Policy is reviewed *de novo*. The scope of this court's review, however, is limited to the evidence that was before Standard at the time of its final decision. *See* Memorandum and Order filed October 17, 1995.

B. Review of Standard's Record

As a threshold matter, Standard contends that, in light of the record before it when it made its decision, plaintiff failed to show that he is so disabled that he cannot perform the material duties of a "civil litigation attorney." Standard's focus is misplaced. The disability clause of the subject LTD Policy explicitly states that an attorney is disabled in the practice of law if he or she is unable to perform the material duties of his or her "specialty" in the practice of law. Plaintiff asserts that he specialized as a "trial attorney" while practicing law. In fact, in determining whether Kearney was

disabled from his specialty, Standard acknowledged that plaintiff's former occupation was that of a "trial attorney" and reviewed whether he was disabled from that position. Ferney Decl., Ex. 34 p. 14. Thus, the relevant inquiry here is whether plaintiff is so disabled that he is unable to perform the material duties of a trial attorney. Plaintiff retains the burden making this showing. Ferney Decl., Ex. 1 at 709;[3] *cf. Miller v. Metropolitan Life Ins. Co.*, 925 F.2d 979, 985 (6th Cir. 1991).

The record on this matter is well developed. On January 27, 1995, when it made its final decision to deny plaintiff's claim for continued long term disability benefits, Standard had before it, *inter alia*, medical evaluations and/or reports submitted by Dr. Lehman, Dr. Morrison, Dr. Smith, Dr. Bittle and Dr. Weinreb. These reports indicate that plaintiff recovered reasonably well physically from his surgery, but may suffer some cognitive deficiencies. They also indicate that plaintiff is now fit to resume legal work in some capacity. Plaintiff argues that these reports also indicate that his mental limitations and related physical restrictions prevent him from resuming the duties of a trial attorney. The court disagrees.

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3. The insuring provision of the LTD Policy states:

> PART 6. LONG TERM DISABILITY INSURING CLAUSE
>
> Subject to all the terms of the GROUP POLICY, STANDARD will pay the LTD BENEFIT described in Part 8 upon receipt of satisfactory written proof that you have become DISABLED while insured under the GROUP POLICY.

Appendix D

The report of Dr. Bittle, which plaintiff submitted to Standard in support of his claim of disability, states:

> I am of the neuropsychiatric opinion that it is highly medically probable that [plaintiff's] memory/concentration and cognitive deficits do interfere significantly with his ability to function in the highly complex arena as a trial attorney dealing with complicated, multifactorial issues as is the case in all trials.

Ferney Decl., Ex. 26 p. 101. This report was "preliminary" however, and thus provides limited support for plaintiff's position. *See Id.* at 99, 100, and 101. The report's impact is also limited by the fact that it is based largely upon Dr. Bittle's review of Dr. Fulton and Dr. Smith's examinations, at least one of whom found that plaintiff is not disabled.[4] *See Pitzer v. Sullivan*, 908 F.2d 502, 506 n. 4

4. Dr. Bittle evaluated plaintiff for approximately two hours at his office and also had plaintiff complete a standard general information medical intake form. He did not administer "psychological testing" because plaintiff had undergone psychological and neuropsychological testing with Dr. Fulton and Dr. Smith. The court was not provided a report by Dr. Fulton. However, Dr. Smith's report concluded.

> It would appear, based on my present examination of [plaintiff], that the primary impediment of returning to full-time employment as an attorney is motivational in origin. He seemed to be of the opinion that, unless he was willing to work 75 hours per week in an almost hypomanic, he could not function as a trial attorney
>
> . . . .

(Cont'd)

(9th Cir. 1990) (nonexamining physician's opinion given less weight than examining physician). As for the "mental status examination" Dr. Bittle did perform on plaintiff, those results appear to more closely tract Dr. Smith's conclusions rather than support his findings that plaintiff's memory and cognitive deficits interfere significantly with his ability to perform as a trial attorney.[5] *See* Ferney Decl., Ex. 26 p. 96.

(Cont'd)

> In summary, my evaluation of [plaintiff] does not reveal any evidence of cognitive, verbal skill, or memory deficits which would preclude him from effectively functioning as an attorney at the present time. By his own estimation, he is capable of functioning at a level consonant with the general IQ of 130. Formal test scores suggest an even higher level of current memory functioning and cognitive skills. I can certainly find no evidence of neuropsychological deficits which would prompt him to be labeled disabled. Those physicians who have drawn such conclusions have done so simply based on the patient's self-report, and not as a result of formal or systematic evaluation.

Ferney Decl., Ex. 19 pp. 177-78. While Dr. Smith did not distinguish between plaintiff's occupation as a trial attorney or a civil litigation attorney, his conclusions are nonetheless relevant.

5. Dr. Bittle concluded after his mental status examination that:

> There was no evidence of and he denied ideas of reference or delusional type of thinking or beliefs. There was no evidence of and he denied auditory or

(Cont'd)

Appendix D

Plaintiff also submitted the report of Dr. Weinreb in support of his claim. Dr. Weinreb's report concludes that plaintiff should be precluded from very heavy work, very severe emotional stress and should not be on a tight time schedule. Ferney Decl., Ex. 26 p. 84. Dr. Weinreb does not, however, find that plaintiff cannot perform the material functions of a trial attorney. The fact that plaintiff should, like most of us, avoid severe emotional stress or very hard work does not warrant the conclusion that he cannot practice as a trial attorney. Indeed, with respect to plaintiff's alleged mental limitations, Dr. Weinreb acknowledged that "[e]ven with the alleged memory problems in this case, [plaintiff] certainly, in depositions, seemed to remember most things quite well, and this would not seem to be a limiting factor for him . . ." *Id.* at p. 85.

(Cont'd)

> visual hallucinatory experiences. The patient was oriented as to time, date, place and person. His estimated intelligence overall is superior. Short term memory: The patient was able to remember a number, color and flower after 10 minutes, and three of three objects after 15 minutes. He could repeat 7 digits forward and 6 in reverse. Remote memory was intact. He was good with dates of past events. He could name the current and preceding eight presidents, the current and preceding four governors of the state in retrograde fashion. Superficially, there appears to be no deficit in learning. However, there may be subtle deficiencies, cognitively. Problem solving was done satisfactorily. He quickly determined he could buy 14 apples if he had a dollar and they cost seven cents apiece. Serial 7's were done quickly and accurately.

Ferney Decl., Ex. 19 pp. 177-78.

As for the remaining evidence in the record, little if any of it supports plaintiff's position. In fact, it largely suggests that plaintiff is fit to resume the work of a trial attorney. The record contains evidence that (1) plaintiff has been classified as a Class I-II in the American Heart Association functional classification; (2) he has an IQ of about 130; (3) he has performed well during tests of his memory functioning and cognitive skills; (4) he plays several sets of tennis on the weekends; (5) he races antique cars up to speeds of 120 miles per hour roughly ten times a year; and (6) Dr. Morrison, an examining cardiologist, concluded that he should be able to return to his usual occupation with in 6 to 12 months of the surgery.

In sum, there is no question that plaintiff's physical and mental stamina has been weakened by his heart condition. Unfortunately, the LTD Policy does not insure that he would forever remain at his former state of health and stamina. Without sufficient evidence that the condition left him so disabled that he cannot perform the functions of a trial attorney, plaintiff's claim fails. Accordingly, because plaintiff has not met his burden of establishing that he is disabled as defined in the LTD Policy, Standard is entitled to summary judgment.

IT IS THEREFORE ORDERED that defendant's motion for summary judgment be, and the same hereby is, GRANTED.

DATED: June 4, 1996

s/ William B. Shubb
WILLIAM B. SHUBB
UNITED STATES DISTRICT JUDGE